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ABSTRACT

A diagnostic treatment center for learning disabilities and emotional problems was developed to serve six school systems. Evaluation by the multidisciplinary staff covered behavior, family background, health, and intellectual, perceptual motor, emotional, and educational functioning. Treatment plans, developed by the team which subsequently met with the school personnel, involved the child in play, and educational or behavioral therapy on an individual or group basis. Treatment also altered the child's environment by providing family therapy and parent counseling, mothers' groups, school or parent conferences, or staff consultants to work with school personnel. Consensual judgment of change (by parents, schools, and staff) in school work, and in educational and behavioral functioning indicated mild improvement in 60.9% of the cases and marked improvement in 16.2%, with girls showing more improvement (p less than .01). Appendixes provide ranking scales and client classification and other forms and describe treatments. Descriptive data are given for a sample of 350 cases. (JD)

OE/BESE
TITLE III

ED036921

SUMMARY AND EVALUATION

OF THE

REGIONAL EDUCATIONAL DIAGNOSTIC TREATMENT CENTER

1966 - 1969

U.S. DEPARTMENT OF HEALTH, EDUCATION & WELFARE
OFFICE OF EDUCATION

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INTRODUCTION

An evaluation of the Regional Educational Diagnostic-Treatment Center was done at the end of its three-year grant. In the original proposal there was no provision for an evaluation and therefore data was not collected systematically throughout the period. However, the following summary of the services rendered and the analysis of our experience should provide useful information both to the region served and for the planning of future projects.

The material to be presented is as follows:

SECTION I	HISTORY OF THE PROJECT AND DESCRIPTION OF THE GOALS
SECTION II	STATISTICAL ANALYSIS OF DESCRIPTIVE DATA
SECTION III	STATISTICAL ANALYSIS OF DATA FOR TREATMENT AND CHANGE
SECTION IV	NARRATIVE EVALUATION OF THE REGIONAL EDUCATIONAL DIAGNOSTIC-TREATMENT CENTER
SECTION V	CONCLUSION

SECTION I

HISTORY OF THE PROJECT AND DESCRIPTION OF THE GOALS

Under provisions of Title III of the Elementary-Secondary Education Act of 1965, the educational leaders of Region III (Bullitt, Jefferson and Oldham Counties) in Kentucky designed and proposed the development of a Diagnostic Treatment Center for six school systems, Bullitt, Louisville, Oldham, Jefferson, Catholic and Anchorage Independent School. This project was devised in accordance with the Title III philosophy of innovative educational development. It was proposed to demonstrate an effective and efficient program for children with emotional and learning difficulties. A multi-disciplinary approach was decided upon as the most appropriate method to evaluate the difficulty and suggest treatment.

Previously, the school systems of Region III had been forced to rely upon their non-existent or overworked psychology departments for direct assistance. Since school personnel are not well informed concerning community resources, they have seldom utilized these services. In contrast, REDTC was school-oriented and because of a thorough familiarity with community resources, was able to bridge the gap between the school, home and community.

The multi-disciplinary structure of the REDTC staff added another unique facet in the way of innovation. Because of this approach, all possible factors contributing to the disability were considered for each child.

The location of the Center and a description of the physical plant is described in Enclosure (1)* entitled Structure. It also includes a description of staff members and assignments.

* (Appendix III)

The Diagnostic-Treatment Center was designed to provide both specific and concomitant services to school children, directed toward learning and behavioral improvement. Major objectives of the Center were:

1. To identify the nature of learning disabilities and emotional problems of school children.
2. To demonstrate to school staffs new and varied methods of approaching learning and behavioral problems.

The major functions of the Center included the following:

1. To evaluate data concerning learning disabilities and/or emotional problems.
2. To identify and diagnose the nature of learning disabilities and/or emotional imbalance.
3. To provide treatment for learning disabilities and emotional problems.
4. To coordinate and facilitate use of available community resources.
5. To recommend placement of children in educational programs existing in school systems.
6. To offer consultant services and in-service education to school personnel.
7. To provide visual, auditory and general health screening for referral to appropriate medical resources.

The first function, evaluation, required interviews with the child, school personnel, parents and any agent that may have worked with the child prior to his being referred to the Diagnostic Center. The aspects of the child's behavior and environmental influences upon his behavior explored by the staff were the following:

1. BEHAVIOR in the various testing and interview situations.
2. INTELLECTUAL FUNCTIONING according to psychological tests and responses to interviewer's questions.
3. PERCEPTUAL-MOTOR FUNCTIONING gleaned from psychological tests and observations (Visual and hearing tests and a general health assessment were included in this area.)
4. EMOTIONAL FUNCTIONING derived from psychological testing, interviewing, and data from the Social History.
5. EDUCATIONAL FUNCTIONING determined from educational testing and an analysis of the child's performance and school record which often included an interview with the classroom teacher.
6. FAMILY BACKGROUND assessed the home conditions, the family constellation, and the developmental history of the child. Any contacts with other service agencies or any unusual medical history was included in the social history.
7. HEALTH SURVEY was conducted by the Registered Nurse. This included contacts with doctors, clinics or other agencies. (See Enclosure 2) (Appendix III).

All referrals received at the Center included a statement of the problem and other evaluation criteria that the school considered significant. The referral was then assigned to the team appropriate for the geographical area of the school. At the team staffing, new referrals were discussed and assigned to a team member who was called the "Prime Mover" and, as such, was responsible for the movement of the case until a treatment plan was initiated.

The number and kind of staff involved varied with the type and severity of the problem. Not all disciplines became actively involved in each case. Nevertheless, all cases were presented for discussion to the team.

REDTC perceived a child as a living, changing being, interacting with a changing environment. A child's environment is made up of school, home and community. His interaction is dependent on his past experiences and the experiences of those with whom he comes into contact. When REDTC became involved, it temporarily became a part of that environment and subsequent interaction and change.

The staff team set out to collect the data which was pertinent to an evaluation of the problem, utilizing information obtained from the school, home and testing. After the data collecting procedures were completed, the staff team met for the purpose of staffing the problem and developing a comprehensive evaluation report for the school and the central office of the school system. An evaluation of the child's problem served one of the following purposes:

1. To confirm what the school staff had hypothesized.
2. To modify to some degree what the school staff had hypothesized.
3. To enlighten the school staff to such an extent that the child could be perceived in an altogether different light.

Three cardinal principles have emerged:

1. The most effective intervention is derived from the efforts of a closely integrated inter-disciplinary team functioning as a unit.
2. The child was best helped when REDTC worked closely with the school staff to assist them to solve the problem.
3. There is no one answer to any problem and there are many different avenues of approach that will bring about change.

At this time it would be helpful to summarize briefly the functions of the following staff members: The educational specialist, the psychologist, and the social worker.

When a learning disability was noted, the educational specialist gave the child diagnostic reading tests to determine the nature of the disability. Her second duty was to work with other staff members to determine what could be done for the child. She worked in a consultant capacity with school personnel, and often suggested teaching procedures that could be implemented with the help of an educational aide from REDTC. An explanation of prescriptive teaching is attached. (SEE ENCLOSURE 3) (Appendix III).

The psychological evaluation involved both interview and testing procedures designed to assess the child's emotional, intellectual and perceptual functioning. The psychologist determined intellectual functioning by means of standard intelligence tests, the WISC and Stanford-Binet, as well as other instruments which measure abilities of children with special problems. Emotional functioning was assessed by means of projective tests, personality inventories, and interview. The tests were evaluated with close attention to the relationship between tests. These results were then compared with those of any previous testing. From the child's interaction with the psychologist in the interview, the latter interpreted attitudes toward authority, interpersonal relationships, self concept, and methods of solving problems. The conclusions thus drawn, hopefully gave an adequate picture of the child's level of emotional, intellectual and perceptual functioning.

Hypotheses derived from psychological testing were often corroborated by data from educational functioning. Conversely, when educational testing indicated specific disabilities, these could be checked by psychological tests.

The social worker at REDTC obtained the social history which included the educational, emotional, physical, and social development of the child. Relationships within the family unit were explored to determine the child's role in the family structure and the effect of the family situation on him. Again, these findings were correlated with those of the testing.

When children who were referred to REDTC had previous contact with another agency, it was the social worker's responsibility to obtain the existing information. Because of her knowledge of community resources, she served as a liaison between REDTC and other agencies. Any referrals or contacts to other agencies were made by a REDTC social worker.

After evolving a tentative treatment plan, the team was ready to meet with appropriate school personnel at a joint conference. At this time the child's difficulties were discussed and the team's evaluations were presented. Resources for treatment plans were explored and an individualized program was developed.

The last major step was the initiation of a treatment plan. Types of treatment provided by the Center staff that directly involve the child were:

1. Individual Therapy
2. Play Therapy (SEE ENCLOSURE 4) (Appendix III)
3. Group Therapy (Counseling in the Secondary School) (SEE ENCLOSURE 5) (Appendix III)
4. Activity Group (SEE ENCLOSURE 6) (Appendix III)
5. Educational Therapy Activity Group (SEE ENCLOSURE 7) (Appendix III)

The Center offered treatment for children which was primarily directed to altering some portion of the child's environment and thus altering his response pattern. Such methods were:

1. Family Therapy and Parental Counseling (SEE ENCLOSURE 8) (Appendix III)
2. Mothers's Group (SEE ENCLOSURE 9) (Appendix III)
3. School Conferences
4. Parent Conferences
5. Serving as consultants to school staff members working with the child.

In brief, the Center helped the child with a learning problem by evaluating his problem, conferring with parents and school personnel about the problem, and devising a treatment plan for the child which involved parents and school. In the three major processes of the Center - Evaluation, Conferring, Treatment - the parents and school were major contributors to the Center's functions. The Center did not work in isolation. The Center served a specialized role in assisting the home and school to help the child minimize his learning problem.

It was anticipated that the school personnel would naturally generalize from these experiences in solving other problems relating to other children. The ideas, methods and resources demonstrated should have wide application for future use.

SECTION II

STATISTICAL ANALYSIS OF DESCRIPTIVE DATA

One of the goals of REDTC has been the definition of the problems encountered. On the Client Identification Form (APPENDIX I) items one through thirty-one with the exception of item eleven (School Change) are variable descriptive of the children seen. This section of the evaluation deals with the statistical analysis of these items. It must be emphasized that the descriptions here are of the problem children referred to us by the six systems. We did find significant differences among these children. We cannot, however, extrapolate from the characteristics of the problem children to the characteristics of the general population of any system. All that can be determined is that the children referred to us showed these differences. Neither can causative relationships be determined by these data. Useful hypotheses concerning the relationships of these observed factors to the problem of children may be made however.

Method

The statistical description of the REDTC population which follows was based upon a sample of 350 cases. These were chosen randomly from the total population of cases initiated by REDTC from September 20, 1966 to January 1, 1969. Of these 1,695 cases, the percentage of the total contributed by each system was determined and the sample population was chosen according to those proportions. Thus, 8.67% of the sample (and total) cases were Bullitt County, 19.76% were Catholic, 35.99% were Jefferson County, 30.91% were Louisville, and 4.66% were Oldham County. The Anchorage Independent School System was eliminated from statistical study because only two cases were referred. The table of random numbers was utilized in order to choose selected cases. Each case chosen for inclusion in the sample was required to meet the following criteria:

1. An evaluation of the case must have been done by a REDTC staff member.
2. The child must not have left the school systems which were serviced by REDTC, either for reason of graduation, transfer, or dropout.

The final 350 cases selected were distributed as follows:

Bullitt	31
Catholic	69
Jefferson	126
Louisville	108
Oldham	16

Discrepancies in the sample are due either to failure to respond to the questionnaire or to a few additional cases which had been evaluated to insure against the effect of failure to respond.

A client classification form was developed in order to describe each case. This is included in Appendix I. Staff members who were involved in the evaluation and treatment of a particular case were requeted to fill out questions 5 through 43. A parent questionnaire(see Appendix I) was filled out by the parent or guardian of the child. Their responses to the inquiries were weighted (see Appendix I). These comprised responses for items 44 and 45.

The school which the child last attended while the case was active with REDTC was contacted and requested to respond to a questionnaire (see Appendix I). These also were weighted (see Appendix I). They comprise the responses to items 46 and 47. The consensual judgment of change (item 48) is the arithmetic average of items 42 through 48. All averages were rounded to the nearest whole numbers. Frequencies, percentages, and chi-squares were determined for each item with regards to the following seven different dependent variables:

Sex of Child
School System from which the case was referred
School Type (Inner-City, Urban, Suburban, Rural)
Total Reading Disability
Degree of Aggression
Degree of Withdrawal
Consensual judgment of change

This section covers only that part of the data descriptive of the children. The analysis of the data relative to the treatment by the REDTC and that data concerned with the outcome or changes seen, is in Section III of this evaluation.

A. DESCRIPTION OF TOTAL SAMPLE:

Of the sample population, cases were distributed as follows:

8.9%	Bullitt County	32.0%	Louisville
19.3%	Catholic	4.6%	Oldham County
35.2%	Jefferson County		

Of the total sample, 76.9% were male and 23.1% were female. The age and grade distributions of the total sample are illustrated in Figure 1(a) and 1(b). It should be noted that these classifications are not directly comparable for two reasons. First, some children have been retained and are thus in lower grades than usual progress would indicate. Secondly, children whose birthdays are such that they enter school older than 6 years 6 months may, at some time, appear to be behind in grade level.

Of the total sample, 81.5% were enrolled in a regular class program. Only two systems have a significant number of special classes. The total sample was classified in regard to school type as follows:

(1) Inner-City School - An urban school receiving Title I, ESEA funds.

(2) Urban School - A school with over 50% of its population residing in the cities of Louisville, St. Matthews or Shively.

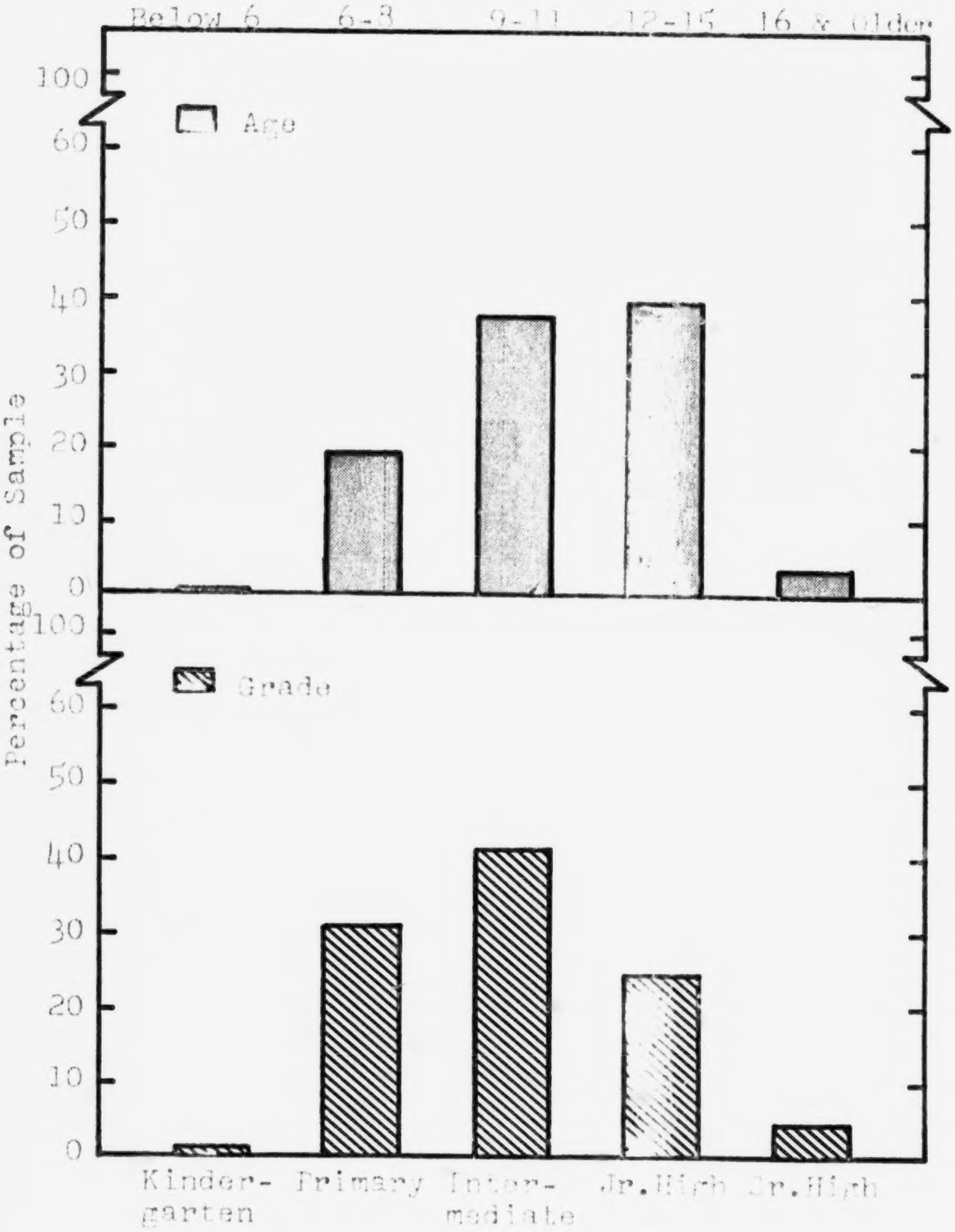

Figure 1a. Distribution of sample by age level.

Figure 1b. Distribution of sample by grade level.

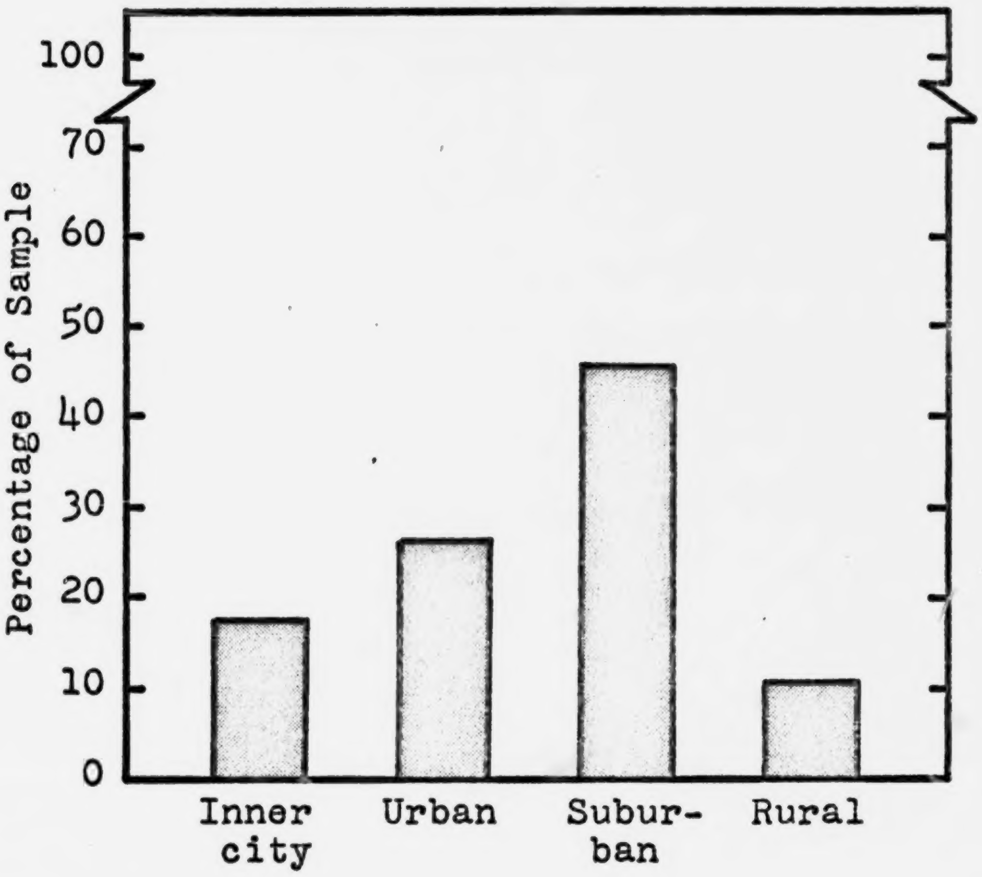

Figure 2. Distribution of sample by school type.

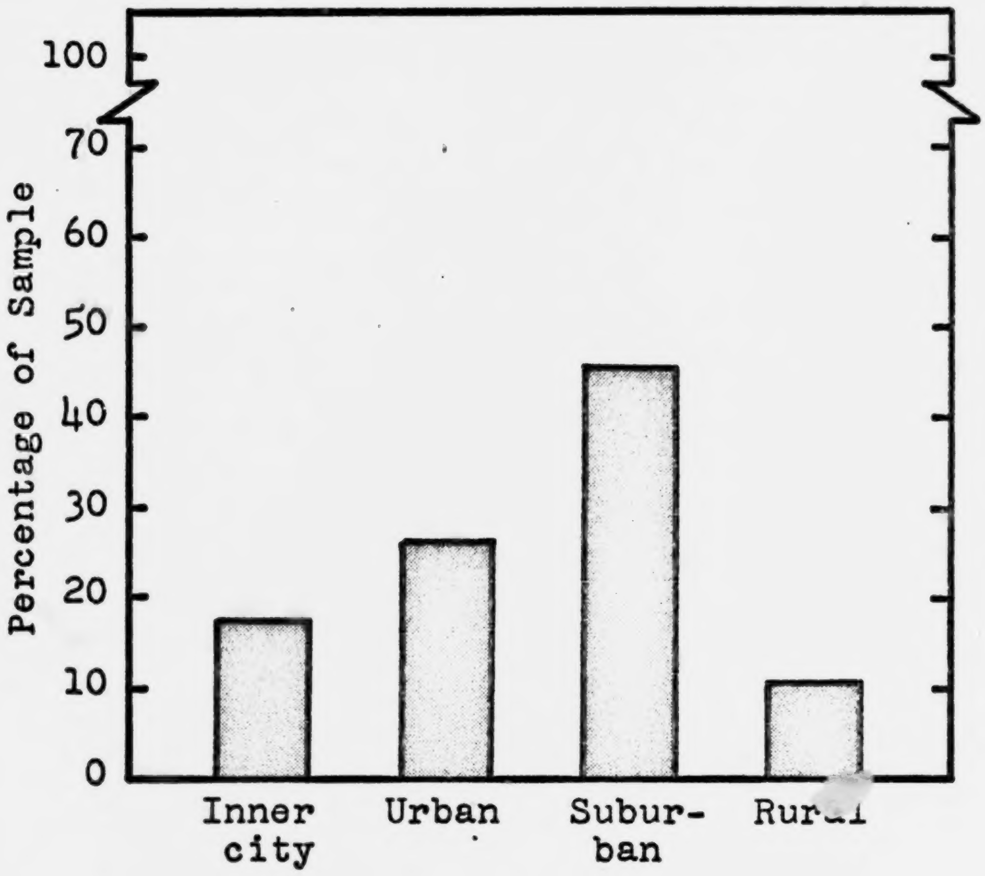

Figure 2. Distribution of sample by school type.

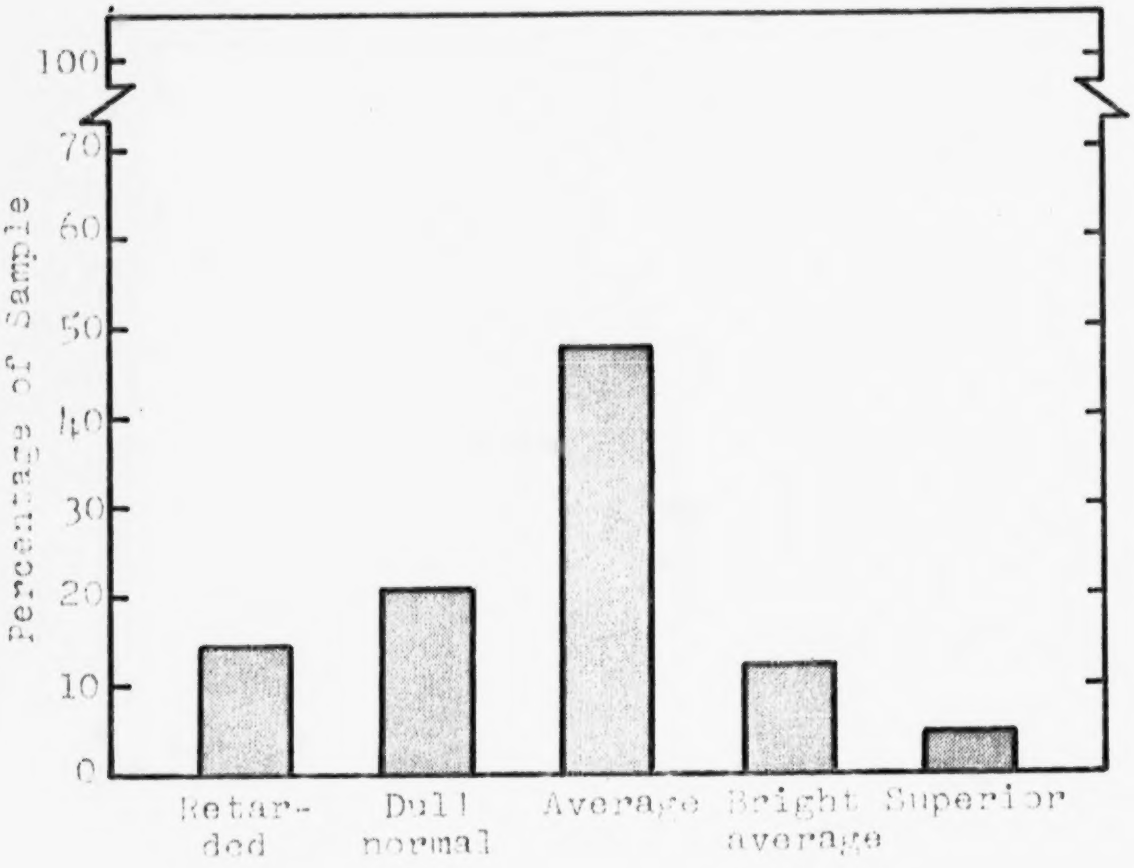

Figure 3. Distribution of sample by intellectual functioning.

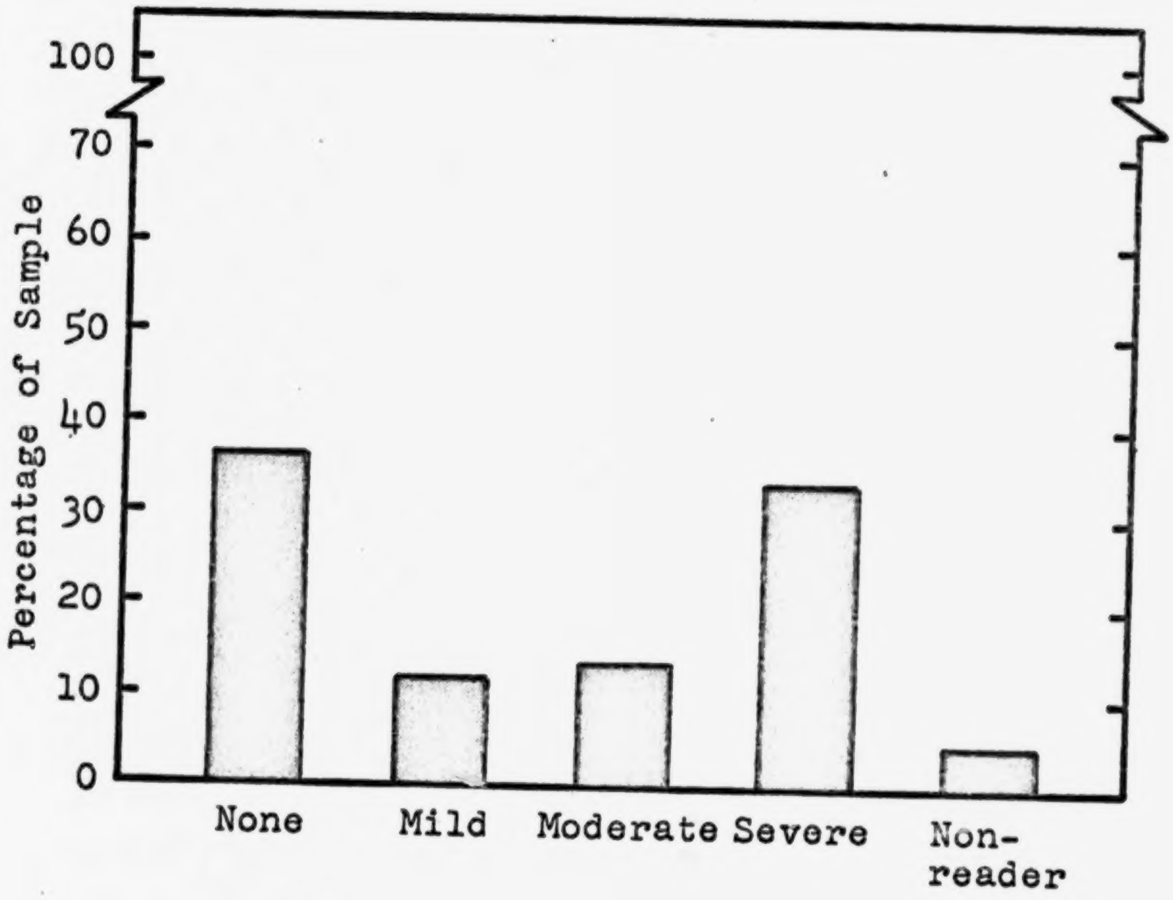

Figure 4. Distribution of sample by total reading disability.

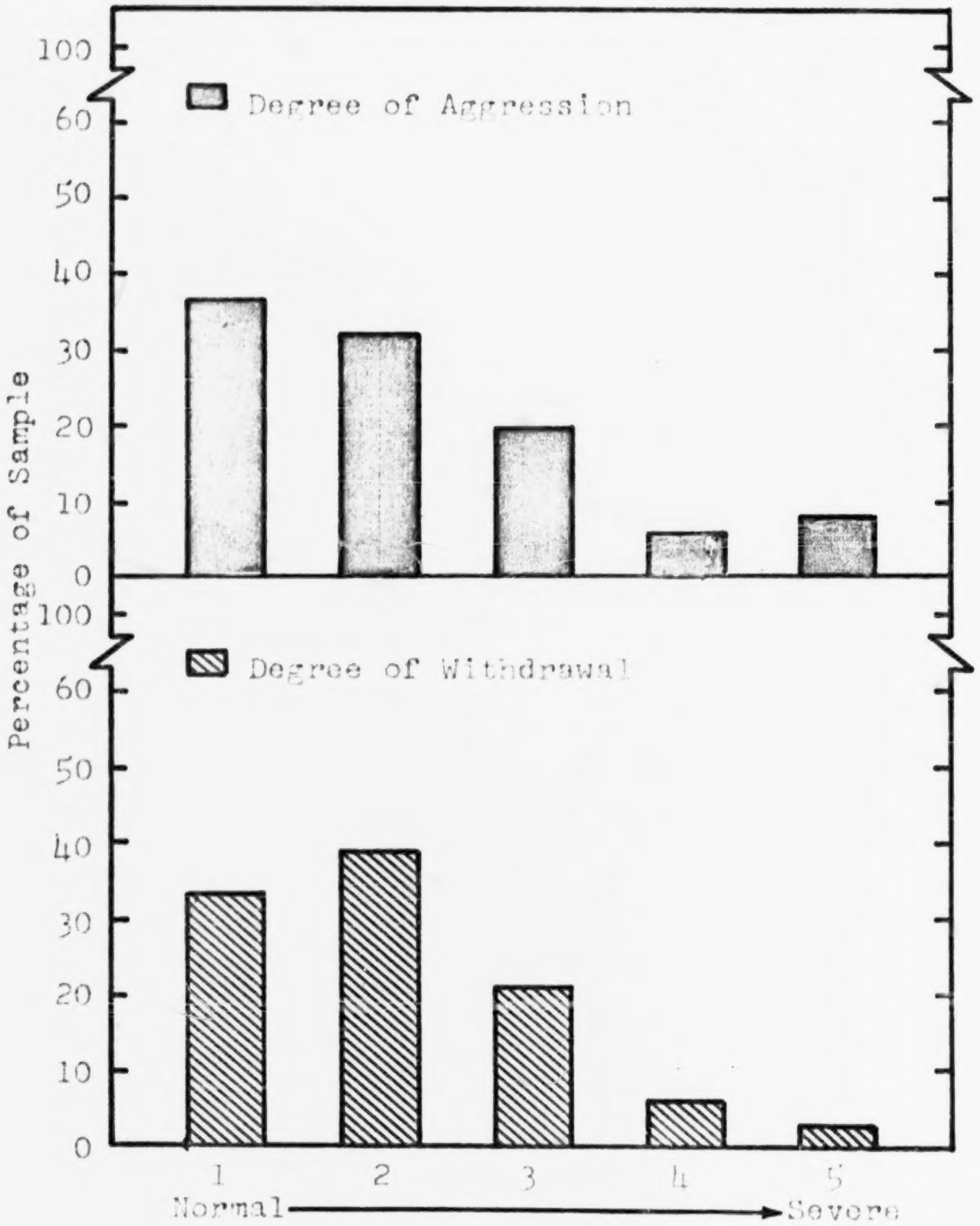

Figure 5. Distribution of sample by degree of aggression.

Figure 6. Distribution of sample by degree of withdrawal.

(3) Suburban School - A school with over 50% of its population residing within the limits of cities other than Louisville, St. Matthews, or Shively.

(4) Rural School - A school with over 50% of its population with rural postal addresses.

The distribution of the sample in regard to these school types is presented as Figure 2.

The estimate of intelligence was, in most cases, determined through administration of a standard individual intelligence test. The majority of cases was tested with the Wechsler Intelligence Scale for Children. The distribution of intelligence estimates for the sample is presented in Figure 3.

Educational evaluations were done on those children suspected of educational difficulties. Severity of total reading disability based on this evaluation was determined according to a table (Appendix II). Those children not evaluated educationally comprise, for the most part, those categorized as having none or a mild reading disability. The distribution of total reading disability is presented in Figure 4.

Although an attempt was made to determine the severity of disabilities in reading mechanics, reading comprehension, writing mechanics, spelling and arithmetic, in over 40% of the cases there were no available data that could be rated accurately.

The degree of aggression and of withdrawal for each case was determined by the staff in accordance with the table in Appendix II. These distributions are illustrated in Figures 5 and 6.

Of the total sample, 92.8% had no problems with sexual adjustment. In the total sample, the percentage of cases having no difficulties in the following areas is:

1.	Gross Motor Problems	79.1%
2.	Fine Motor Problems	76.1%
3.	Perceptual Disability	72.5%
4.	A Visual Impairment	80.7%
5.	Hearing	93.4%
6.	Arrested Medical Problems	81.0%
7.	Untreated Medical Problems	88.5%

The definitions for perceptual disability, arrested medical problems and untreated medical problems may be found in Appendix II.

The socio-economic level for each child was classified into five categories. This is illustrated in Figure 7.

Parent status was determined and the distribution appears in Figure 8. Family problems (as defined in Appendix II) were determined by the REDTC staff members. The distribution of family problems for the sample is depicted in Figure 9.

B. RELATIONSHIP OF SEX OF CHILD TO OTHER DESCRIPTIVE ITEMS:

Analysis of the data in regard to sex differences revealed few significant results with the exception of the strikingly high incidence of male referrals. The proportion of approximately 3 males to 1 female referral was consistent for all school systems except Oldham County, where 31.3% were males and 68.7% were females.

Notable findings in regard to sex differences in the sample are as follows:

1. A slightly higher, but non-significant percentage of girls was placed in E.M.H. classes than were percentage of boys in E.M.H. classes.
2. Boys have significantly more difficulty in both reading mechanics ($p < 05$) and comprehension ($p < 05$) than girls.
3. There was a non-significant trend for boys to have more difficulty than girls in the other academic areas.

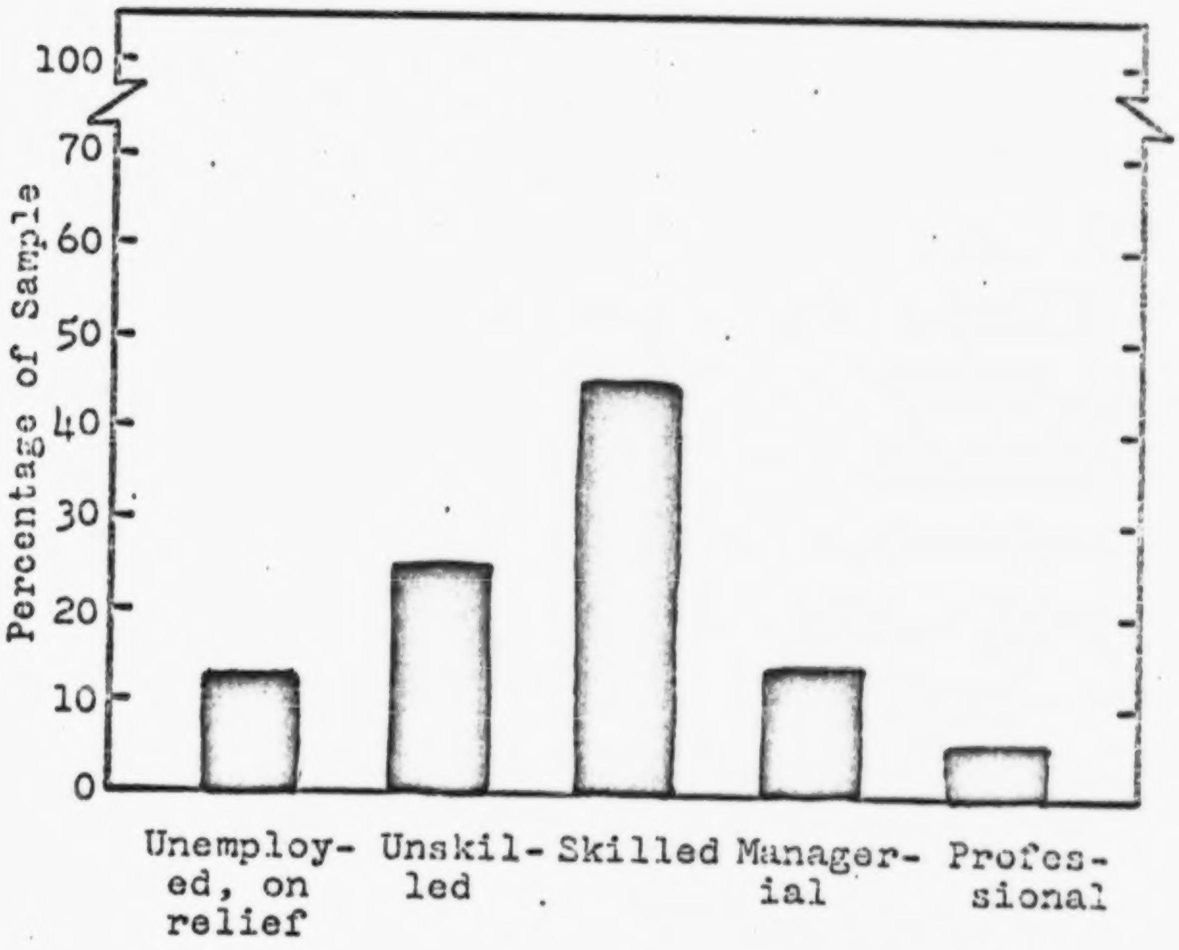

Figure 7. Distribution of sample by socioeconomic level.

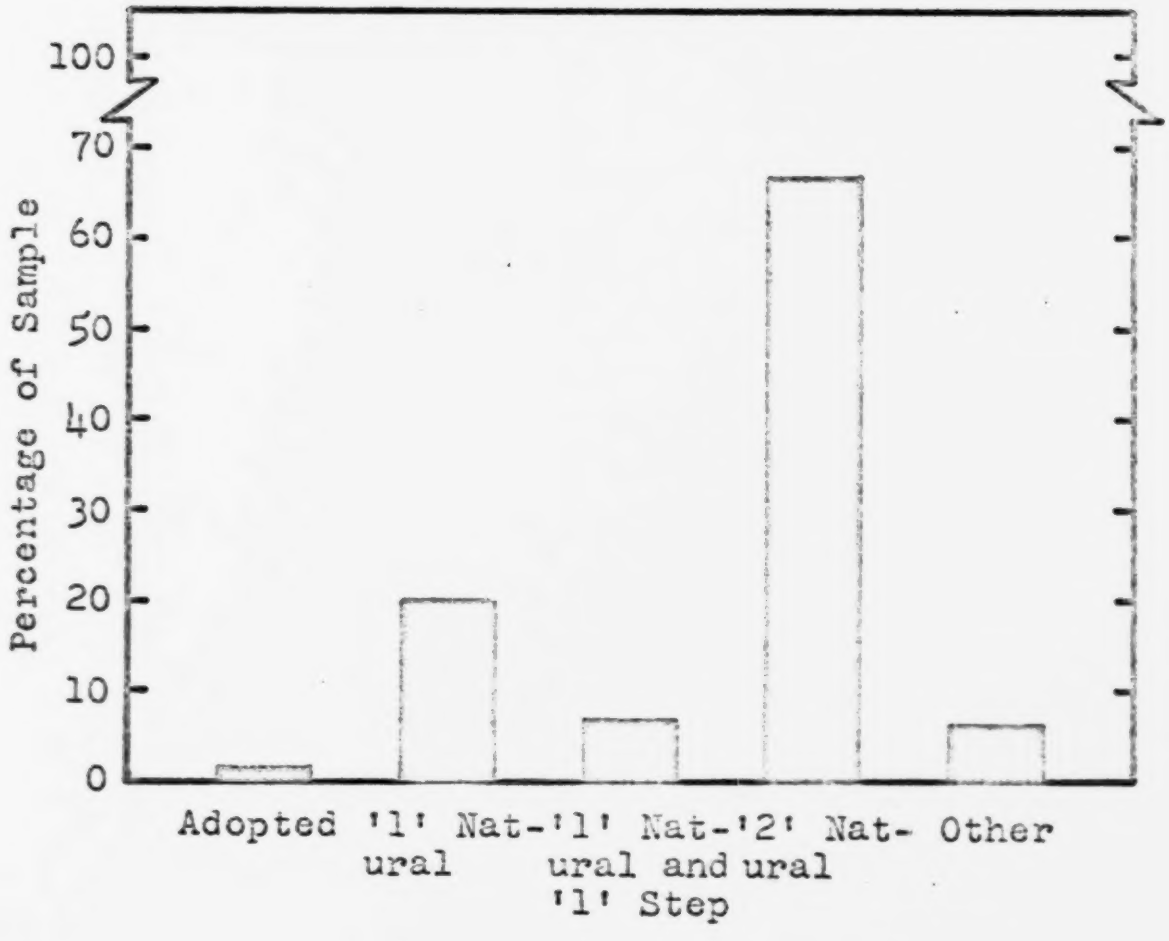

Figure 8. Distribution of sample by parent status.

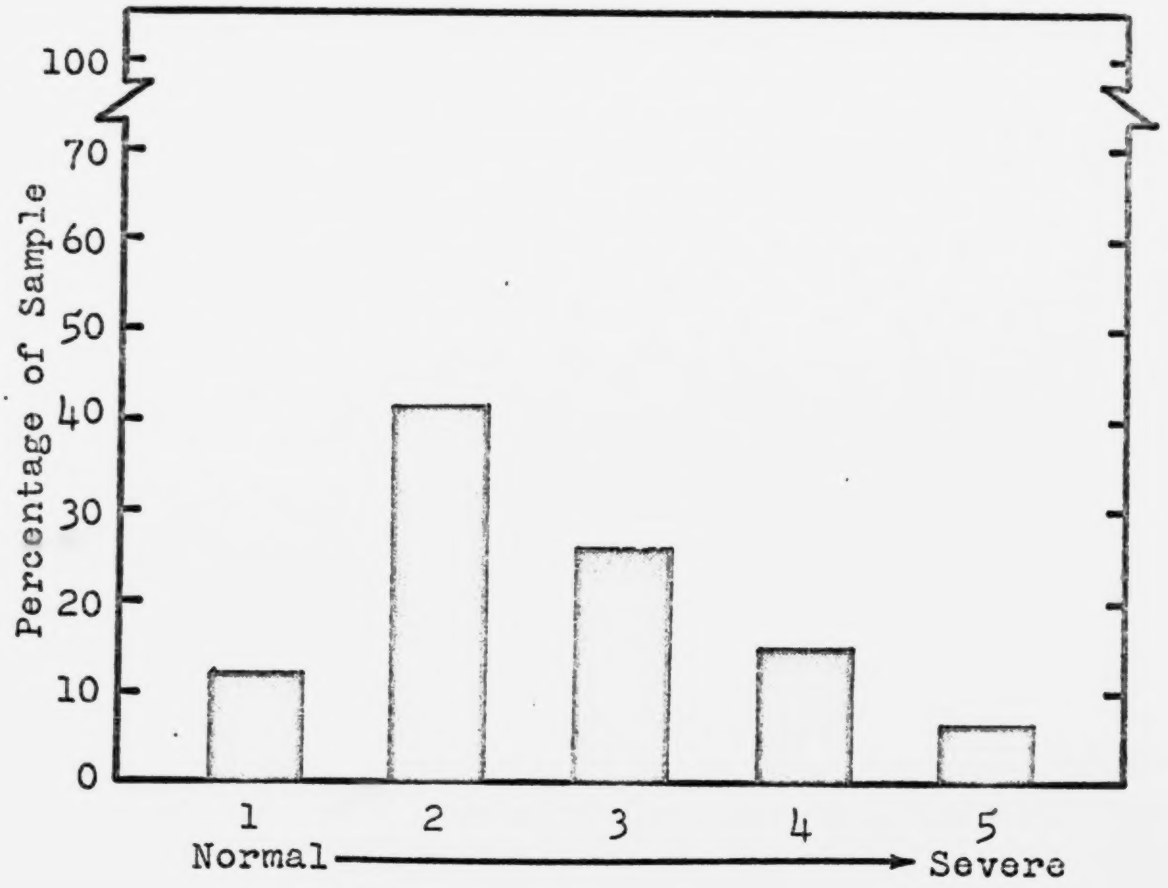

Figure 9. Distribution of sample by degree of family problems.

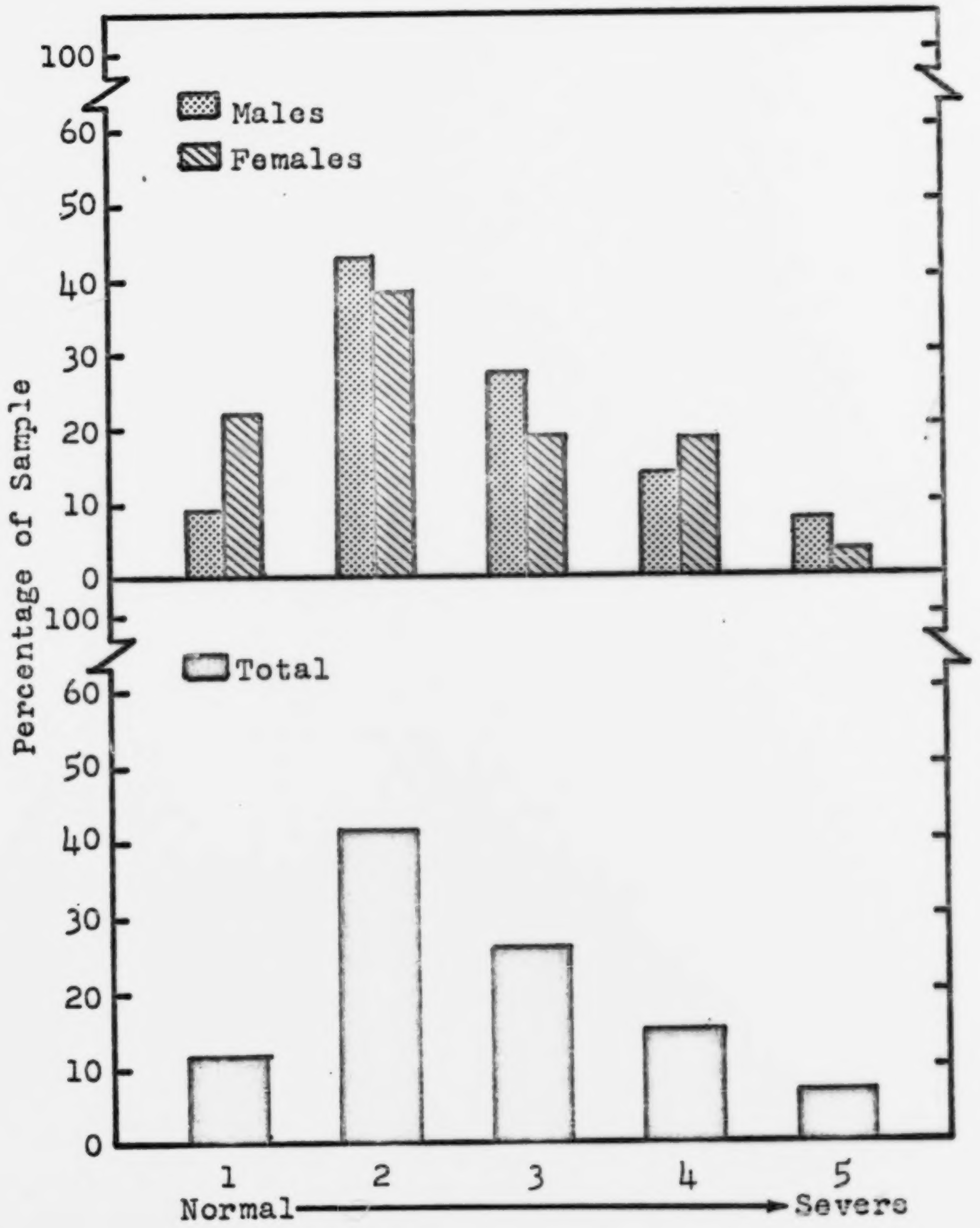

Figure 10. Relationship between sex and degree of family problem.

4. In the areas of gross motor coordination, fine motor coordination, and perceptual disability, there was a non-significant trend for boys to have more severe problems than girls.
5. There were significantly ($p < 05$) more hearing problems among girls and an insignificant trend in the same direction for visual problems.
6. There was a significant ($p < 025$) trend for girls to have more untreated medical problems and a non-significant trend in the same direction for arrested medical problems.
7. There was a significantly higher incidence of severe family problems among boys than among girls ($p < 025$). This is illustrated in Figure 10.

C. DESCRIPTION OF SAMPLE IN REGARD TO READING DISABILITY:

Findings regarding sample differences in regard to reading disability included:

1. 47% of children with severe reading disability were in the 9 to 11 age group. This is significant ($p < 01$).
2. 53.9% of children with severe reading disability were in the intermediate grades. This is significant ($p < 005$).
3. Of the 81.5% of the total sample enrolled in a regular class program, only 39.7% of those were seen as having no reading problem. Of those in the regular classroom, 30.1% had a severe reading disability. This is significant ($p < 005$).
4. Of the non-readers, 68.8% were retarded.
5. Of the children with average intelligence, 38.6% had no reading problem, but 28.3% had a severe reading disability. This is significant ($p < 005$).
6. There was a highly significant ($p < 005$) relationship between degree of total reading and each of the following disabilities: reading mechanics, reading

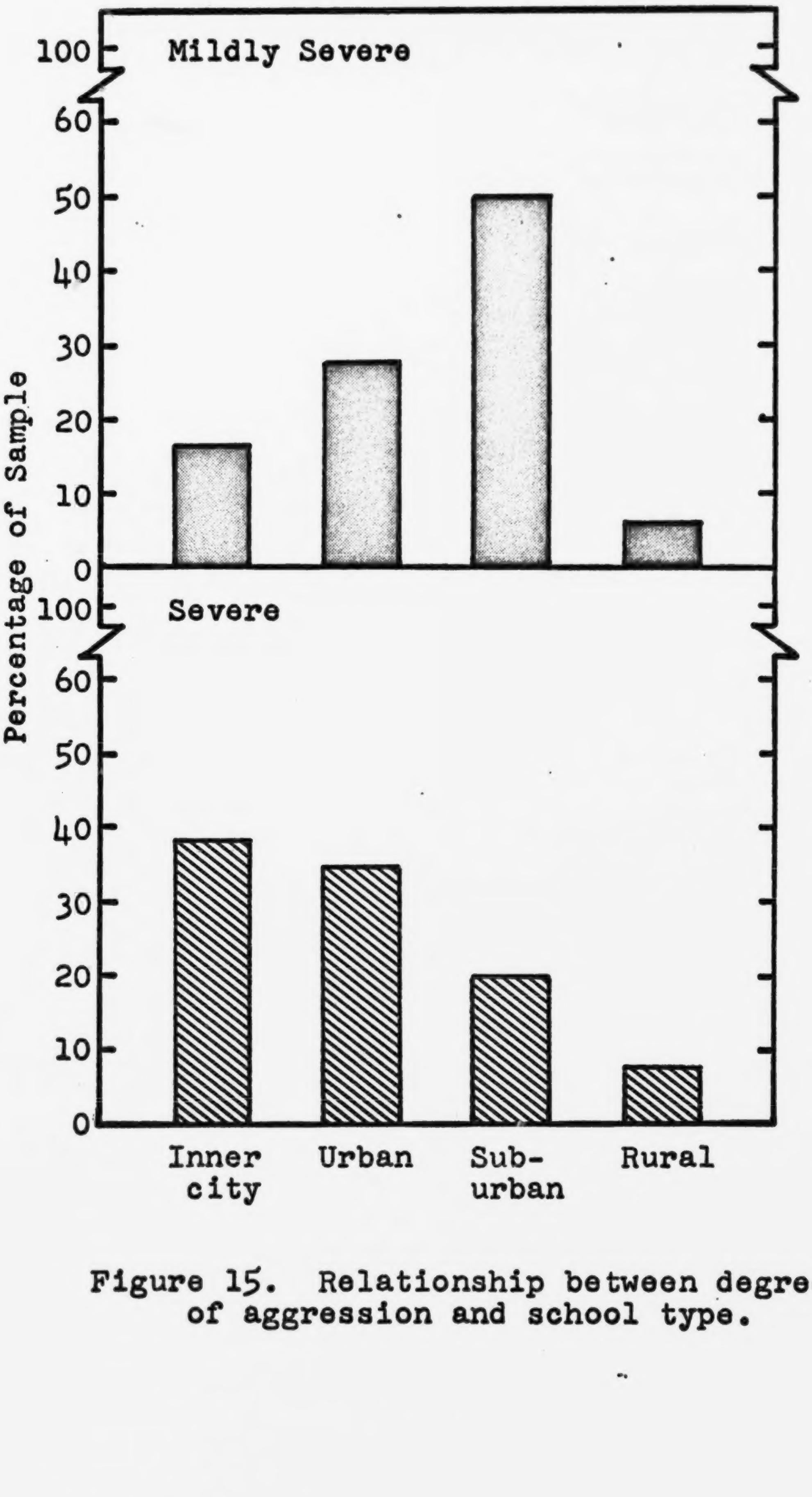

Figure 15. Relationship between degree of aggression and school type.

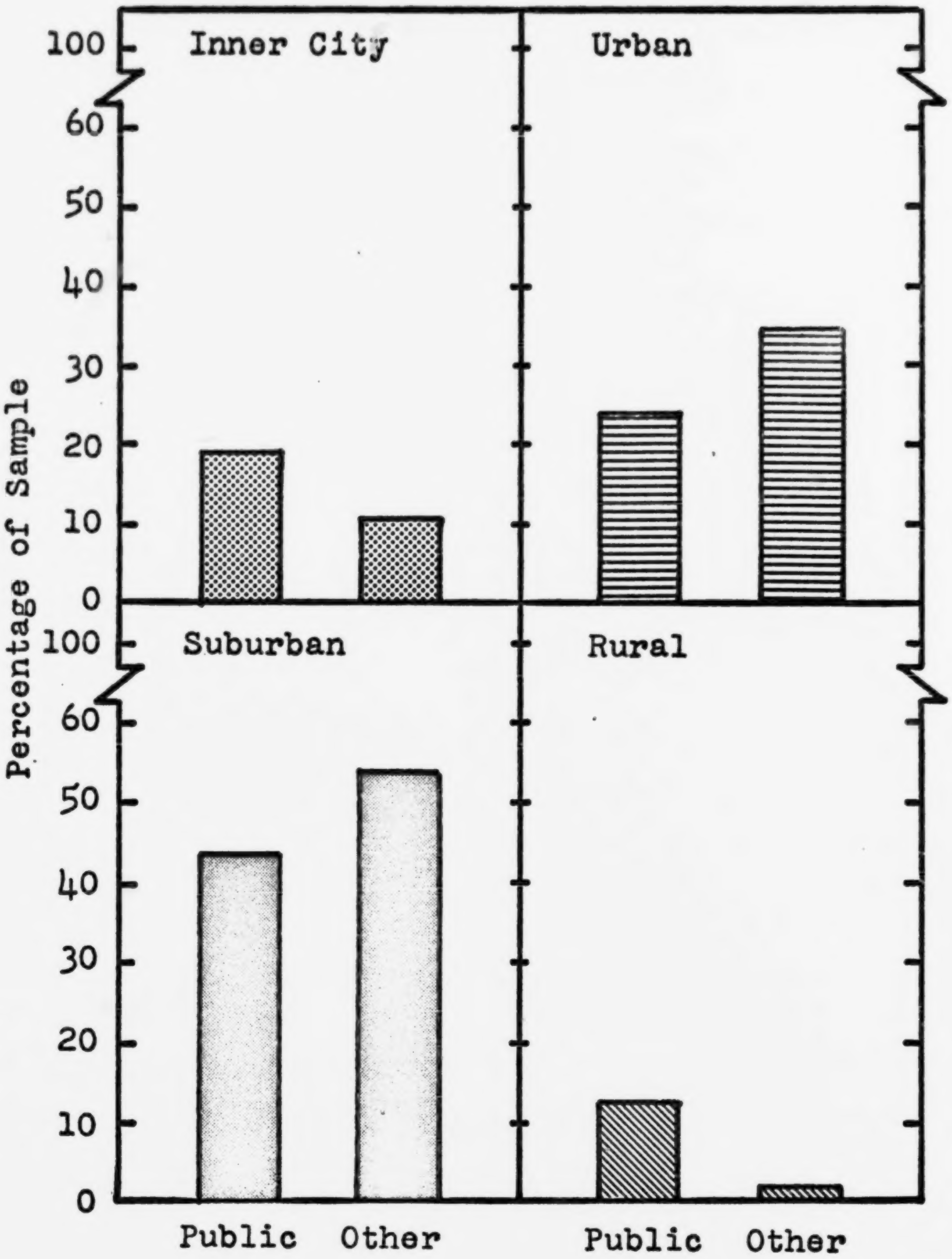

Figure 13. Distribution of public and non-public schools by school type.

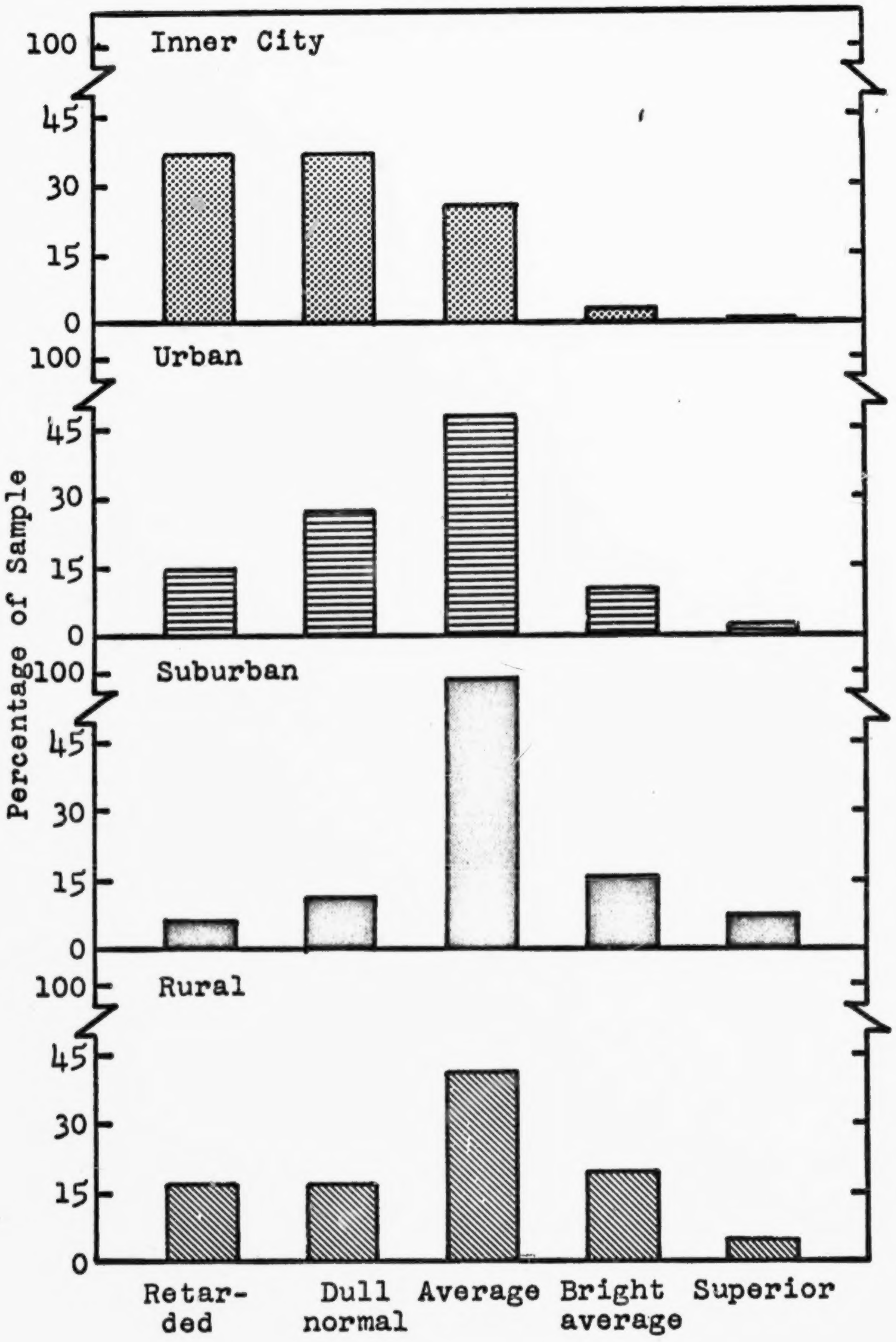

Figure 14. Relationship between school type and level of intellectual functioning.

1. Of the severely aggressive children, 65.4% were 12 to 15 years old.
2. Over 75% of the children judged as aggressive were found in regular classroom programs.
3. A significant ($p<025$) difference was found between grade level and degree of aggression. The following illustrates this finding:

   18.9% of primary grade level children are at least moderately aggressive.

   35.5% of intermediate grade level children are at least moderately aggressive.

   40.5% of Junior High grade level children are at least moderately aggressive.

   53.3% of Senior High grade level children are at least moderately aggressive.

4. Of the moderately severe cases, 55.6% are in the intermediate grades.
5. There was a significant relationship ($p<01$) between aggression level and level of intelligence. Of those judged severely aggressive:

   53.9% had below average I.Q.
   38.5% had average I.Q.
   7.6% had above average I.Q.

6. Of the moderately aggressive, only 27.8% were below average in level of intelligence.
7. In the superior I.Q. students, 12.5% had no aggression problems and 12.6% had moderately severe or severe problems of aggression.
8. Of the E.M.H. children, 58.8% had no problems of aggression.
9. There appeared to be a trend toward mild aggression in the superior children.
10. If aggression is present in a child with a low I.Q., it tends to be severe, but most low I.Q. children do not have problems of aggression.
11. 66.7% of those with marked gross motor problems had no problems with aggression.

12. 69.3% of severely aggressive children came from unemployed or unskilled group.

    38.9% of moderately severe aggressive children came from unemployed or unskilled group.

    50.0% of moderately severe aggressive children came from skilled group.

    Therefore, the bulk of severe aggression problems appears to be from the homes of the unemployed or unskilled. Aggression problems decrease with the rise in socioeconomic level.

13. If there is no family problem, 58.5% of the cases will have no aggression problem.
14. 57.7% of severe aggression problems have moderately severe or very severe family problems.
15. Of the severely aggressive children, 50.0% had both natural parents. Of the moderately severely aggressive children, 66.6% have either one or both natural parents. Aggression does not seem to be positively correlated with the lack of natural parents.

E. DESCRIPTION OF SAMPLE IN REGARD TO LEVEL OF WITHDRAWAL:

Findings in regard to level of withdrawal in this sample are described below:

1. 33.3% of the severely withdrawn are between the ages 12-15.
2. Those children rated severe or moderately-severe in regard to withdrawal, comprised only 7.8% of the total sample, whereas 12.7% of the total sample were moderately severe or severe in regard to aggression.
3. In the sample, there were no moderately severe or severely withdrawn children over the age of 16. This may indicate a tendency for withdrawn children to drop out of school.
4. 22.2% of the severely withdrawn children are in E.M.H. class placements.

5. There was no general trend in the relationship between level of intelligence and withdrawal. However, in our sample, none of the severely withdrawn children had I.Q.s above average. This apparent relationship between severity of withdrawal and low tested intelligence level may be a function of two factors. First, it may be that the withdrawn child is penalized in individual intelligence testing. The other possibility is that the child with a low level of intelligence may be perceived as withdrawn as a function of his intellectual limitations. In either case, closer scrutiny is warranted.
6. 55.0% of the severely withdrawn children have mild gross motor difficulties. This is significant ($p < 005$). 55.5% of severely withdrawn children have problems in fine motor coordination ($p < .01$). Thus there appears to be a positive relationship between children with motor problems and children with severe withdrawal problems.
7. There is also a trend for the withdrawn child to have visual impairment and medical problems. Of the severely withdrawn children, 22.2% had marked visual problems. Only 44.4% of severely withdrawn children had no arrested medical problem.
8. 88.9% of the severely withdrawn children had moderately severe or severe family problems. This is highly significant ($p < 005$). All moderately severe or severely withdrawn children had some family problem.

F. DESCRIPTION OF SAMPLE IN REGARD TO SCHOOL TYPE:

The following are descriptive statements regarding the sample considering school type.

1. The description of the sample distribution comparing school type by school (Public, Non-Public) is presented in Figure 13. This is significant ($p < 01$).

2. The distribution of I.Q. by school type is presented in Figure 14. Significant ($p < .005$) results indicate that there are different distributions of I.Q. for different school types.

3. 68.6% of retarded children attended inner-city or urban schools.

4. There was a non-significant trend toward greater reading problems in inner-city schools.

    52.5% of inner-city children had severe reading disability or were non-readers.
    35.6% of of urban children had severe reading disability or were non-readers.
    33.5% of suburban children had severe reading disability or were non-readers.
    38.9% of rural children had severe reading disability or were non-readers.

5. Of those children having no reading difficulty, 48% were from the suburban schools, 29.1% from urban schools, 13.4% from inner-city schools, and 9.4% from rural schools.

6. Severe reading mechanics and comprehension problems were present in over 50% of the inner-city children.

7. 56.0% of inner-city cases showed more than mild aggression, whereas only approximately 30% of cases from each of the other school types showed more than mild aggression.

8. The distribution of severe and moderate aggression by school type is indicated in Figure 15. This distribution is significant ($p < .005$).

9. A significant ($p < .005$) relationship between withdrawn and school type was determined:

    29.5% of inner-city cases showed more than mild withdrawal
    25.0% of urban " " "
    25.0% of suburban " " "
    37.0% of rural " " "

10. There was a significant ($p < .005$) trend for mild and moderate withdrawal to be concentrated in the suburban areas.

11. Of the public school referrals, 37.8% have no withdrawal problems, but of the non-public school referrals only 14.7% have no withdrawal problems. This is significant ($p < .005$). Note that 33.3% of public school cases are not aggressive but 47.1% of non-public school cases are not aggressive. This is also significant ($p < .025$).

12. There is a trend for arrested medical problems to be concentrated in urban areas.

13. Figure 16 indicates the highly significant ($p < .005$) relationship between school type and socioeconomic level.

14. A significant ($p < .005$) relationship was found between school type and parent status. It is noteworthy that 54.1% of inner-city children have only one parent. In urban and suburban areas over 70% of the children have both natural parents. 19.5% of the rural children live in family situations which lack a natural parent.

15. The following table represents the incidence of moderately-severe or severe family problems in this sample for each school type.

Inner-City	32.8%
Urban	25.5%
Suburban	16.4%
Rural	13.9%

It is interesting to note that only 2.8% of the rural families were seen as having no family problem. Bullitt County comprised the majority of rural cases.

G. DESCRIPTION OF SAMPLE IN REGARD TO SCHOOL SYSTEM:

The following items were noteworthy regarding school systems:

1. Of the oldest age group (16+ yrs.), 46.2% were from Jefferson County.

2. Only two of the school systems, Louisville and Jefferson County, have a significant number of children enrolled in special classes.

3. The distribution of I.Q. level by school system is highly significant ($p < .005$). These data are represented in Figure 17. It should be noted that 54.9% of the retarded children in this sample was in the Louisville System, 50% of the superior children was in Jefferson County, 47.2% of the dull normal children was in the Louisville System, 46.4% of the average I.Q. was in the Jefferson County System. None of the Oldham County sample was above average in intellectual functioning.

4. (a) 86.9% of inner-city sample was from Louisville System.
   11.5% of inner-city sample was from Catholic System.
   (b) 63.3% of urban sample was from Louisville System.
   25.6% of urban sample was from Catholic System.
   (c) 62.7% of suburban sample was from Jefferson County System.
   22.2% of suburban sample was from Catholic System.
   (d) 61.1% of rural sample was from Bullitt System.
   33.3% of rural sample was from Jefferson County System.

5. 62.5% of E.M.H. children was from the Louisville System. 71.4% of children in P.H. classes was from Louisville. For additional information see Figure 18.

6. The relationship between school system and total reading disability in the sample was highly significant ($p < .005$). 81.3% of the non-readers was from Louisville.

7. The following table represents the percentage of children in the sample in each of the school systems having moderate or severe reading disability.

67.7%	Bullitt County	37.8%	Louisville
53.7%	Catholic	56.0%	Oldham County
44.2%	Jefferson County		

8. Of the Oldham County sample, 50% have severe disability in reading mechanics, 50% have severe writing disability, 50% have severe reading comprehension disability, 50% have severe spelling disability.

9. The distribution of severe aggression among school systems is illustrated in Figure 19. This was significant ($p < 005$).

10. In the Oldham County system, 56.3% had no aggression problem. In the Catholic System, 46.3% had no aggression problem. In the Bullitt County System, 35.5% had no aggression problem. In the Jefferson County System, 33.6% had no aggression problem. In the Louisville System, 29.7 had no aggression problem.

11. The following table illustrates the percentage of the sample from each school system showing no withdrawal problems:

14.9%	Catholic
23.0%	Jefferson County
32.3%	Bullitt County
46.7%	Oldham County
54.1%	Louisville

12. It is interesting to note that 72.1% of the Jefferson County sample showed mild to moderate withdrawal and 76.1% of Catholic System showed mild to moderate withdrawal.

13. While only a small percentage of the total sample had gross motor problems, 66.7% of those who did were from Louisville.

14. Louisville had a greater percentage of children having fine motor coordination problems than did the other systems.

15. Bullitt and Oldham Counties had a greater percentage of children showing P.E. problems than did the other systems.

16. 26.9% of the Catholic children had arrested medical problems. The other systems had significantly less ($p < 025$). However, of the severe problems noted, 73.3% was in the Louisville System.

17. The distribution of the significant relationship between school system and socioeconomic level may be found in Figure 20. This is significant ($p<005$).

18. The significant relationship between family problem and school system is depicted in Figure 21. This is significant ($p.<005$).

SECTION III

STATISTICAL ANALYSIS OF DATA FOR TREATMENT AND CHANGE

This section is in two parts. The first summarizes the statistical analysis of the kinds of treatment given by the REDTC. The second part describes the judgments made by the REDTC staff, school personnel, the parents of the children, and finally the consensual judgment derived from the mean of the three judgments. This data are to some extent an evaluation of the REDTC goal to innovate and demonstrate methods of treatment to the schools.

The data from the three judgments are not directly comparable because they are not all made on the entire sample. For example, the staff judged only those children whom they had actually treated whereas the school judged the entire sample with the exception of three cases. Children who had had no behavior problem thus were marked unchanged by the school as well as those whose problems had not been alleviated. Similar artifacts are present in the judgments regarding educational improvement. This was also often true for the parents' form. These inconsistencies are naturally mirrored in the consensual judgments. The total change also is the mean for both judgments regarding educational change and judgments of behavioral change.

Another source of error is the inter-score reliability. Although an attempt was made to give specific instructions, there was considerable variance among the scores. Furthermore, it was sometimes necessary for school personnel to make judgments upon children whom they had not known prior to the REDTC evaluation.

In general, the REDTC staff judgments as calculated in the original data were less favorable than either the school or parents. The parents were the most favorable, i.e. saw more improvement. Therefore, the consensual judgment is closest to that of the school.

The original data have been corrected, however, in the data reported for staff judgments of behavioral change and educational change by calculating the percentages on the basis of those judged (N = 175 rather than 347).

THERAPY

The REDTC utilized many methods or combinations of methods for intervention in order to ameliorate presenting problems. A description of each will follow.

1. Conference - The conference was the method of intervention used first and most frequently. At these conferences, which could include any combination of school personnel, parents, REDTC staff and other involved persons, the results of the REDTC evaluation were discussed and treatment plans were evolved. Further intervention might be planned or the conference itself could serve as a source of information directing environmental change. Of the total sample, only 3.5% had no conference. The distribution of conferences by school system is a significant one ($p < 005$) which is illustrated in Figure 22. Other interesting data concerning conferences include:
    a) There was a significant trend to have a greater percentage of conferences for boys than girls.
    b) The REDTC tended to have a much greater percentage of conference contact with schools than parents. Only 6% of the total sample did not have school conferences, but 29% had no parent conference.

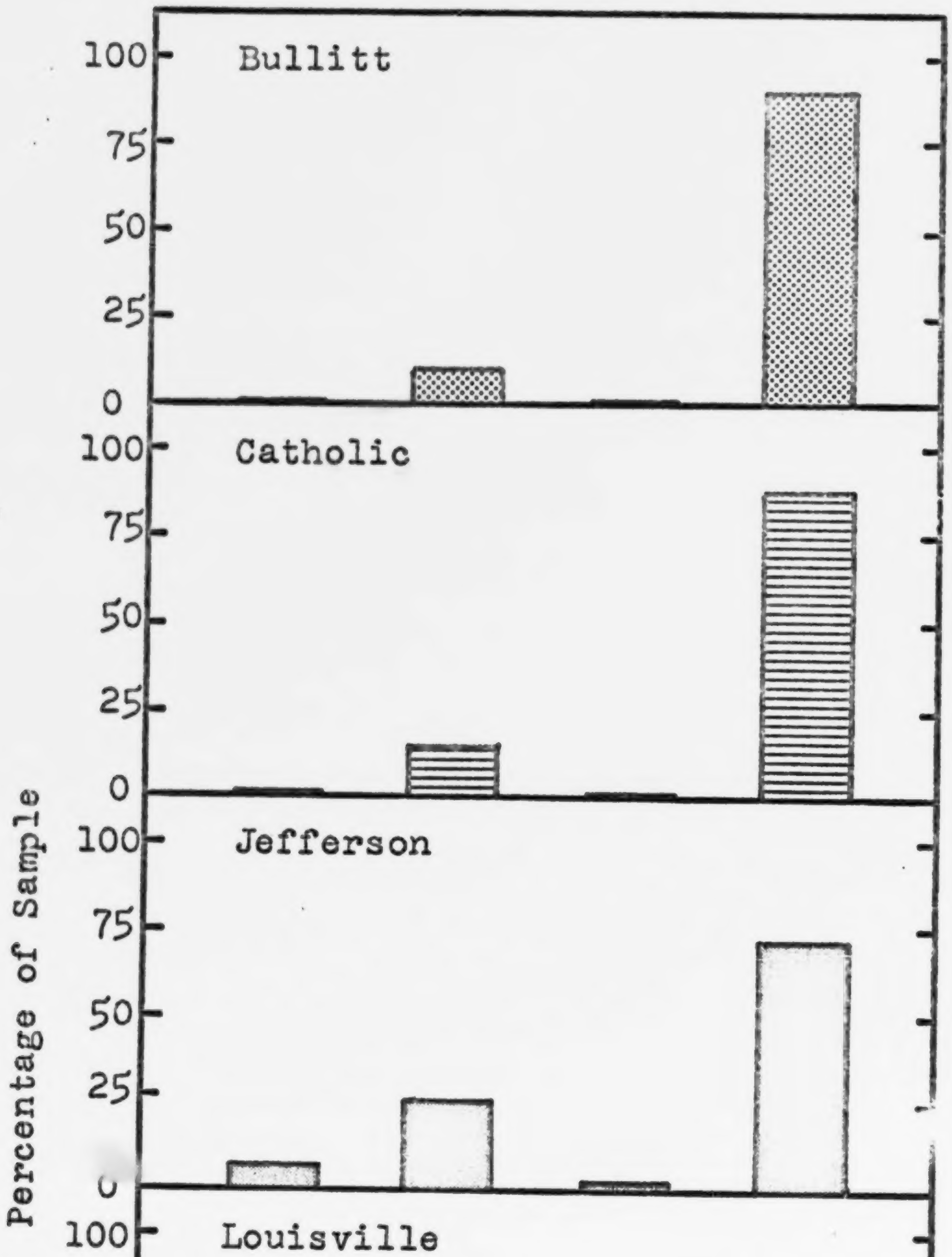

Figure 22. Distribution of conferences among school systems.

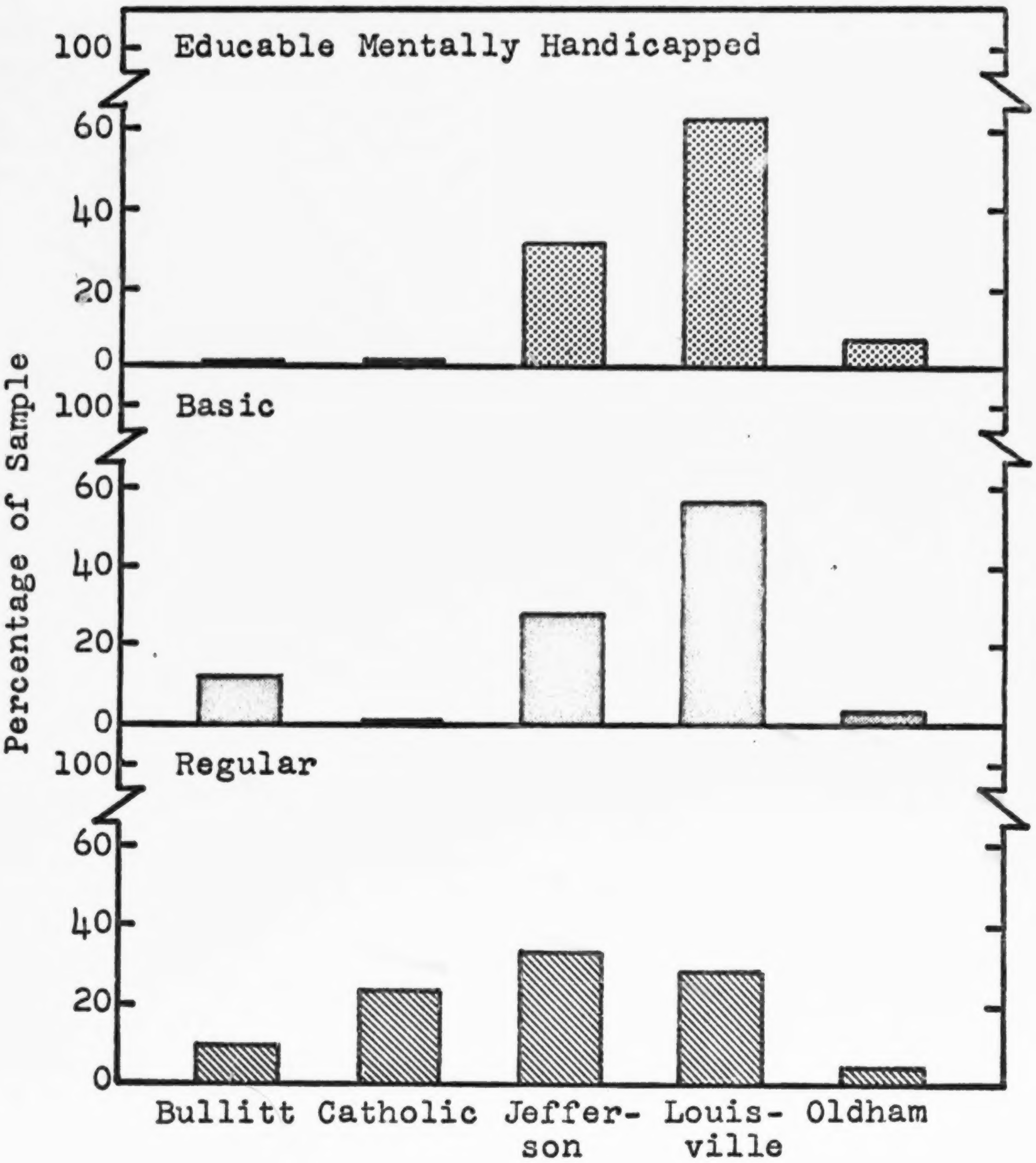

Figure 18. Distribution of educable mentally handicapped, basic, and regular class type among school systems.

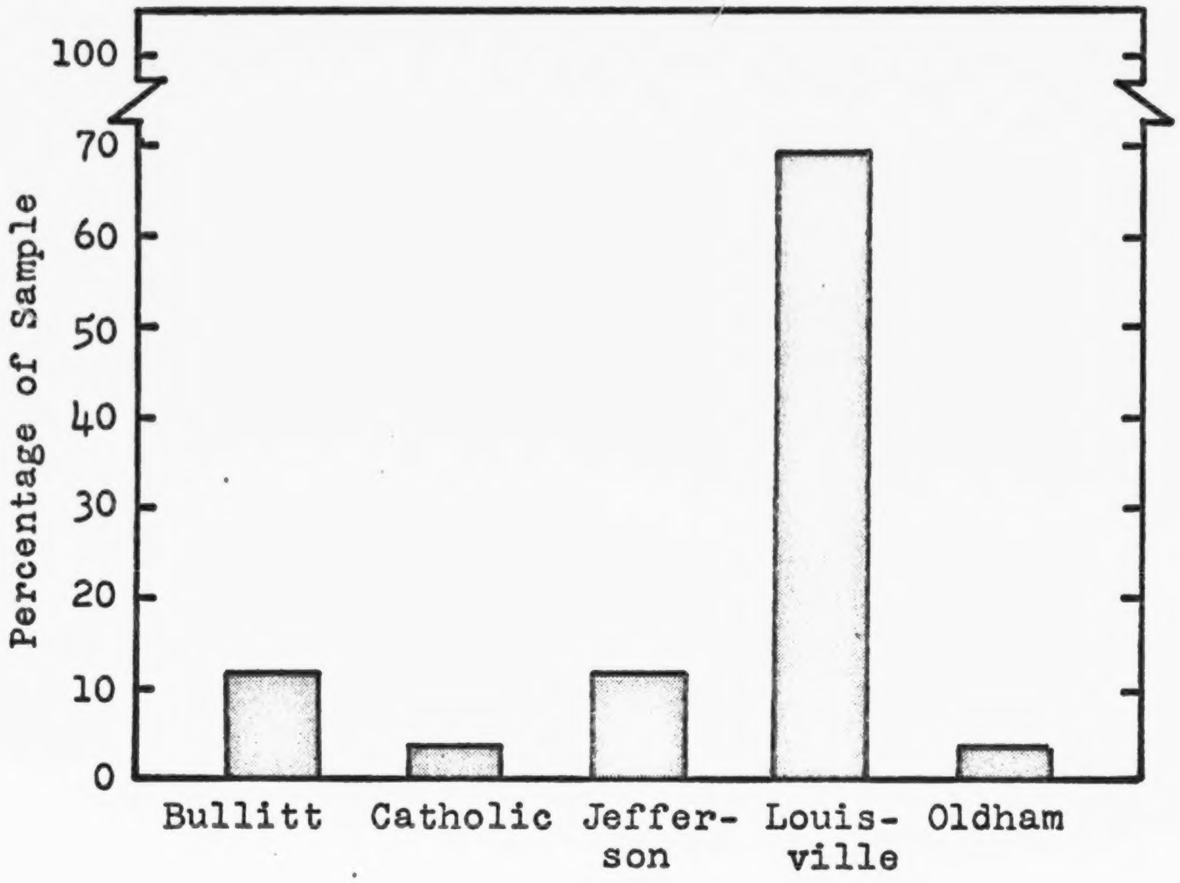

Figure 19. Distribution of severely aggressive children among school systems.

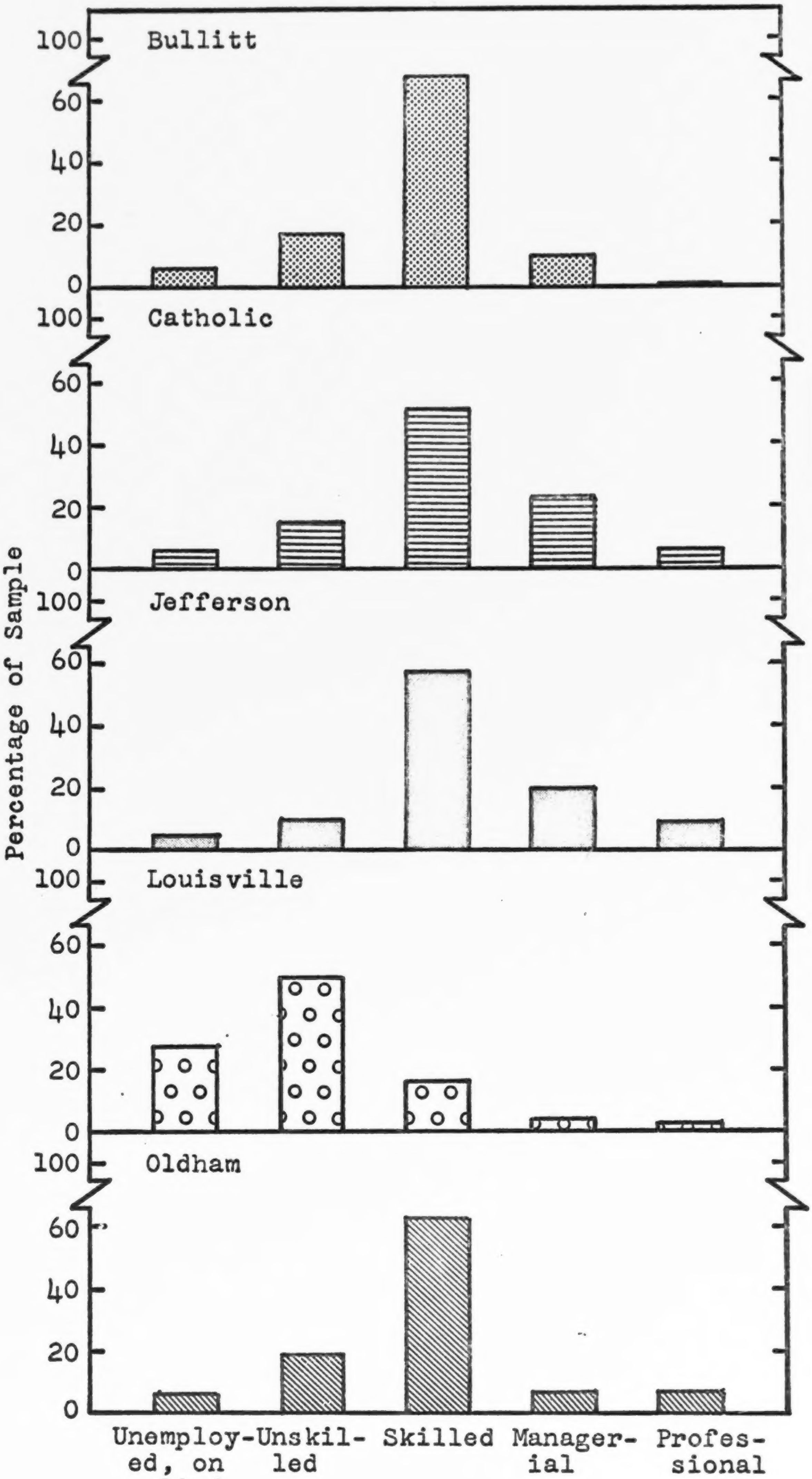

Figure 20. Distribution of socioeconomic level among school systems.

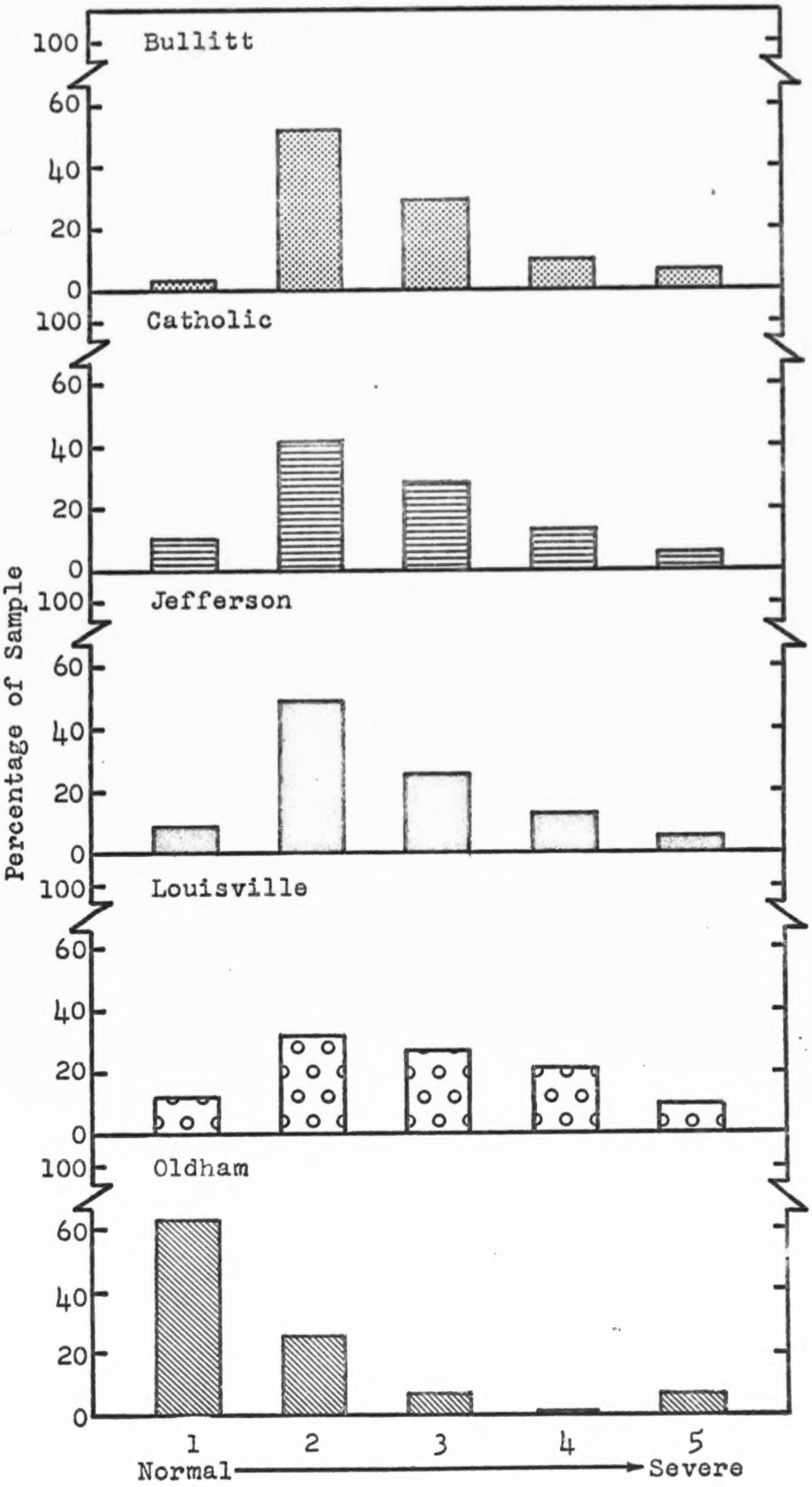

Figure 21. Distribution of degree of family problems among school systems.

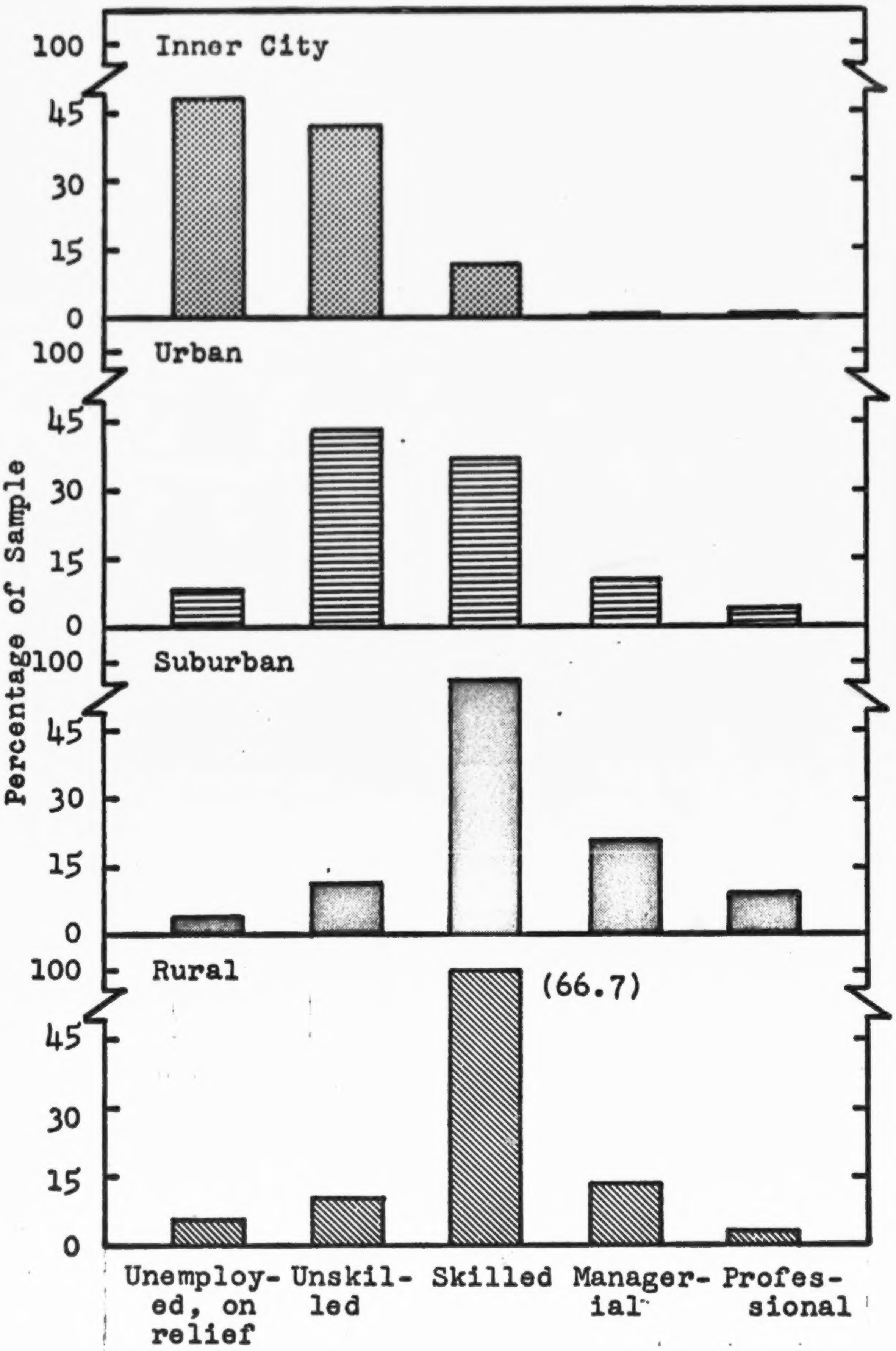

Figure 16. Relationship between school type and socioeconomic level.

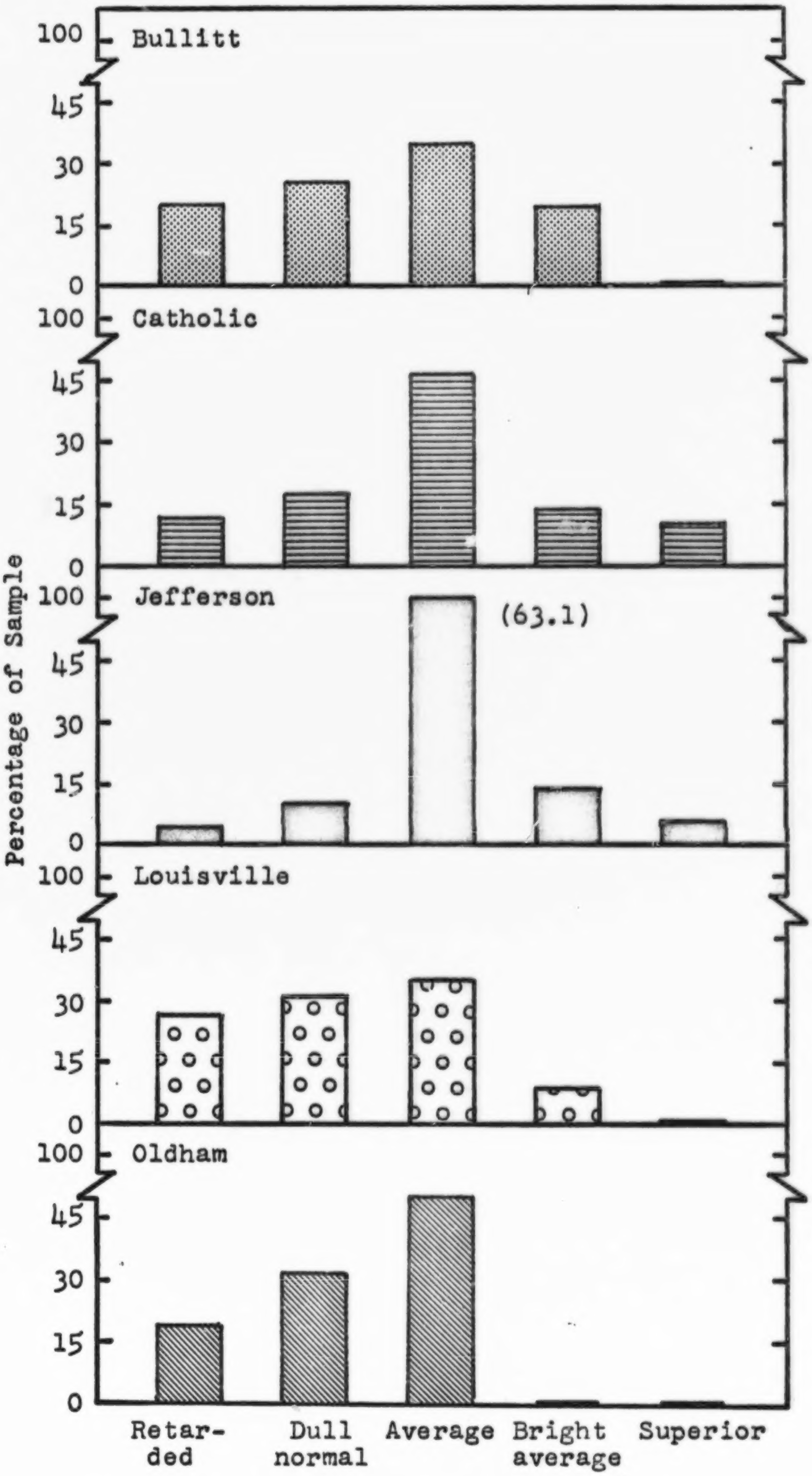

Figure 17. Distribution of levels of intellectual functioning among school systems.

comprehension, writing, spelling, and arithmetic.

7. A significant number of children having difficulties in the areas of gross motor, fine motor, perceptual, visual and hearing functioning, and arrested and untreated medical problems also had severe reading disability. It should be noted that more than 50% of the children with reading problems did not have problems in these areas. Thus their presence increases the likelihood of reading disability, but the presence of reading disability does not indicate a high probability of these problems also being present.

8. There has been considerable interest in the relationship between the development of reading skills and the presence of problems of aggression or withdrawal. The data was not statistically significant although possible trends may be observed. The relationships are presented in Figure 11.

9. Of the children with severe reading disability, 45.2% had no aggression problems, but only 35.7% had no withdrawal problems.

10. The data indicated a tendency for children with mild reading disabilities to be mildly withdrawn.

11. 55.0% of severely withdrawn children had marked reading and other academic disabilities. The sample of these, however, is quite small.

12. There was a highly significant relationship ($p < 005$) between reading disability and socioeconomic level. Figure 12 illustrates the severity of disability for each socioeconomic level.

13. Of the small sample of children living with neither natural nor adoptive parent or parents, 50% had severe reading disability.

D. DESCRIPTION OF THE SAMPLE IN REGARD TO DEGREE OF AGGRESSION:

Regarding the degree of aggression, the following findings were noticeable:

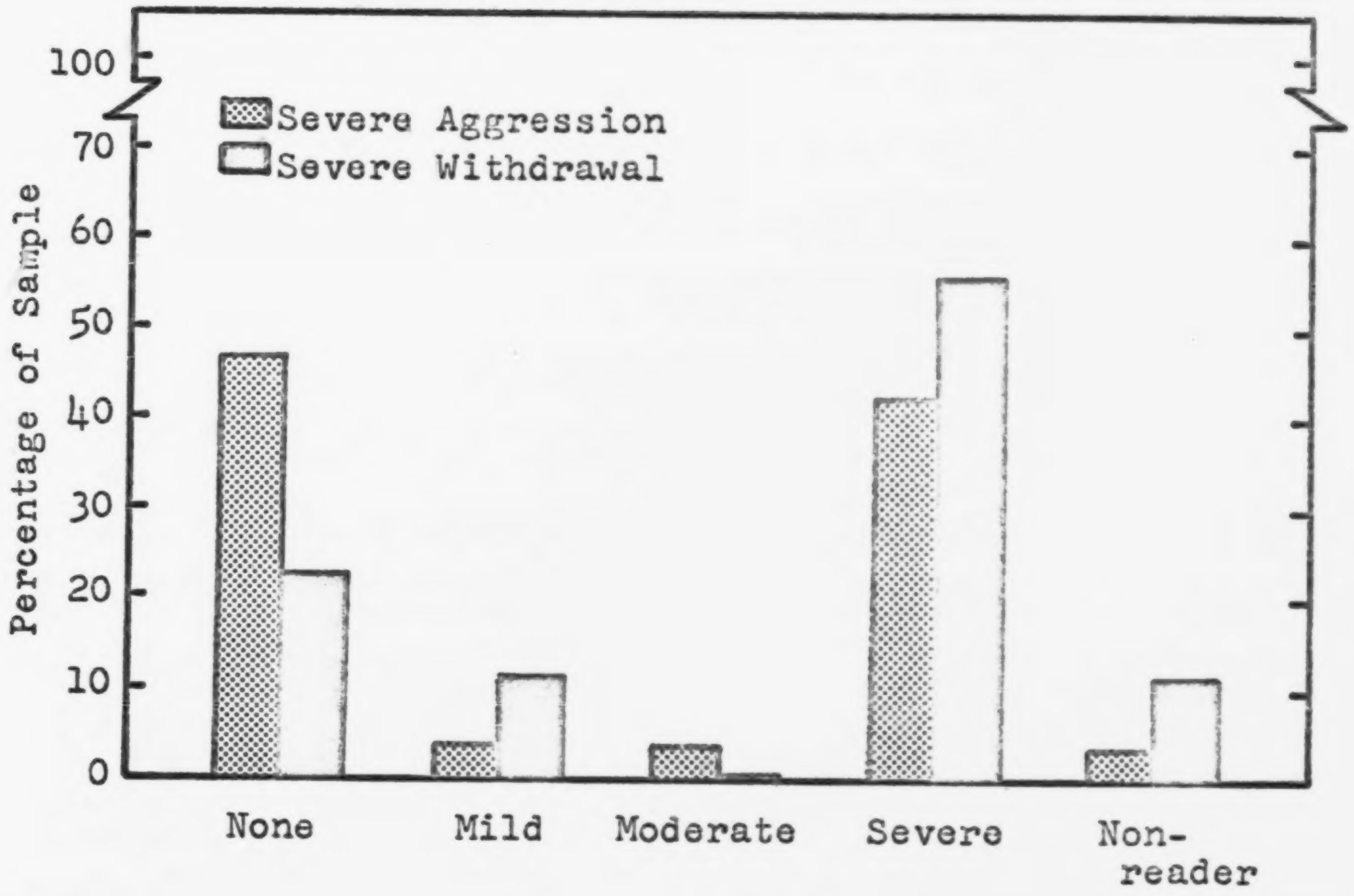

Figure 11. Relationship between total reading disability and behavioral problems of aggression and withdrawal.

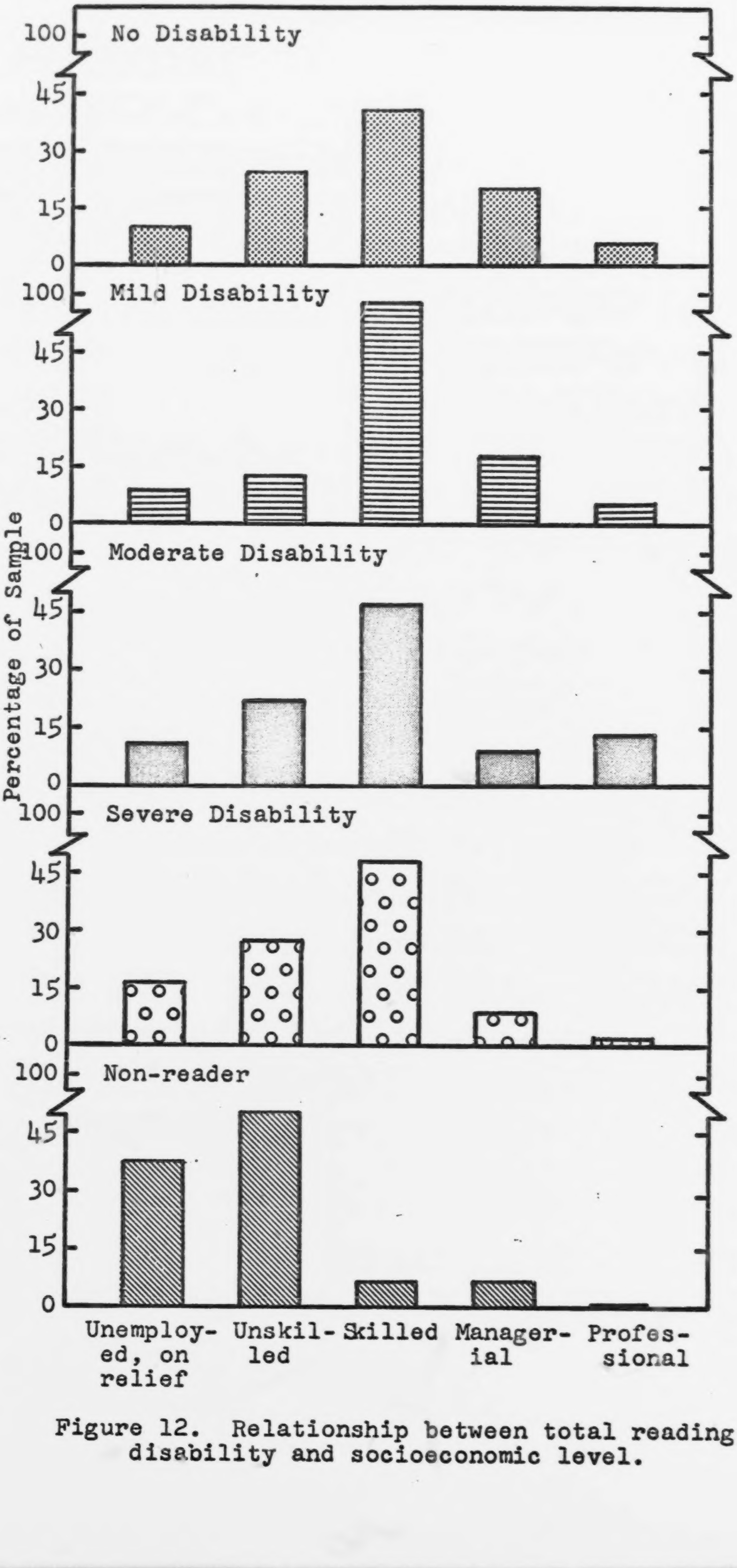

Figure 12. Relationship between total reading disability and socioeconomic level.

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WHY PLAY THERAPY?

Play is recognized as a natural medium of learning for the child. The word, "therapy", comes from the Greek noun servant, whose verb form means to wait. It has no verb in English. It represents a process going on, observed and assisted, perhaps, as the therapist waits for the child to be willing to face himself and to develop in accordance with his own individual nature. The waiting is a positive force, a commitment of faith in the child as a person with individual integrity.

Play therapy is an intensified process of maturation -- an opportunity wherein the child learns new ways of responding in situations that were difficult for him. The therapist, who acts as a catalyst, facilitates a relationship by accepting him as he is, trusting him, and believing him to be capable of self-direction, thus freeing him to discover himself and to gain a sense of self-esteem.

Each individual is said to have certain basic needs which he strives constantly to satisfy. A. H. Maslow's theory of a hierarchy of needs is that the most basic needs are physiological (hunger, thirst, sex), then comes a need for safety, love, self-esteem, and, lastly, for self-actualization. He says that only when the most basic needs are satisfied can the individual strive for self-realization, but that there is a constant inner drive toward fulfillment of this goal.

Based on this theory is the belief that the same inner drive can create a pattern of maladjustment if he is entirely blocked from self-expression or if he has been "detoured" in some manner and has never learned adequate or acceptable ways of achieving self-actualization. The child fights for a right to be himself and in play therapy he is given the opportunity to channel this inner growth into a constructive and positive way of life.

The child is given the opportunity to play out his accumulated feelings of tension, frustration, aggression, insecurity, fear, confusion, and bewilderment. He is encouraged to face himself and to regain touch with his real feelings. He brings them out in the open and gradually learns to control them or he abandons them.

He may have to regress before he can proceed to a creative use of his mature self. As he becomes more relaxed, he begins to realize the power within himself to be an individual. When he can look squarely at himself and regard himself as worthwhile, he is on the road to a self in control -- a growing self and not one involved only in defending and maintaining itself.

However, the therapeutic process does not automatically occur in a play situation. It becomes possible within a therapeutic relationship where the therapist responds with constant sensitivity to the child's feelings, accepts his attitudes, and conveys a consistent sincere belief in the child and a respect for him.

Having read the foregoing description of the dynamics of play therapy, you have probably already decided which children could benefit from such an experience. These would include the hostile, rebellious ones, the insecure, anxious child, the isolate, the withdrawn, the rejected, the fearful, the depressed child and, usually, any child with learning problems or any of those so often termed problem children.

Individual play therapy, group therapy, or combined individual and group contacts may be planned according to the needs of the child as dictated by his problems.

Ideally, a well-equipped playroom is available, but this is not absolutely necessary. It is possible to hold therapy sessions in almost any unused room where one could be uninterrupted. The therapist can bring play materials in a suitcase for each meeting. It is rather important, however, that it be the same place each time, and that sessions be on a regularly scheduled basis.

A specially equipped play therapy room is described in some of the books listed in the bibliography.

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GROUP COUNSELING IN THE SECONDARY SCHOOL

Our past two years' experience has given us the belief that group counseling can be an effective means of behavior modification in the junior and senior high schools. Out of our experience we have formulated a guide, which is far from exhaustive, which indicates in outline form how such a program should be planned and offers an abbreviated description of the process itself.

PLANNING FOR GROUP COUNSELING

Planning requires decisions. Decisions require information. To be successful, a group should be carefully planned and due consideration given to the following decisions. In turn, these must be understood by both the leader(s) and the members and form the basis of a contract among the group members, including the leader(s). These should be written down by the leader(s) for future reference and assessment.

I. Goals

There should be a clear purpose understood. In general, we find the limited goal approach far more useful in the school setting. However, generalized goals also may occasionally be used satisfactorily.

A. Limited goals:

1. Each member specifies what he perceives to be his chief problem and solution of the identified problem for each member represents the goals. (Example: Clowing in class)

2. The entire group meets to deal with a single problem common to all members. An example is a group known to be writing and passing obscene notes in school.

B. Generalized goal of individual growth toward responsibility with the specific behaviors discussed arising spontaneously from group discussion.

C. Evaluation of progress toward goals:

1. The leader(s) should have in mind some predetermined measure to evaluate change. Examples might be truancy rate, number of times sent to the office, grade point average, dropping out of specific behavior (from teacher checklists), etc.

2. Optimally there should be a trained consultant available with whom the leader(s) can assess progress toward goals. This is particularly true in the absence of a co-leader. Where no consultant is available, a peer should be asked to serve.

II. Group Composition

The following variables should be considered in choosing group members. Some are co-related as, for example, number of leaders and sex of group. Concern is not for homogeneity, but balance. An example of co-relationship is that it is unwise to mix youngsters still under parental control with a group of older pre-delinquents; the converse, however, is often desirable.

A. Leaders:

Group counseling may be done effectively by leaders of widely different backgrounds, i.e., counselors, teachers, housewives, etc. The nature of the group will, of course, depend upon the training of the leader. A leader must possess an attraction for youth and enjoy working with them. He must be able to be open-minded and undefensive, yet secure in his own sense of values. Hopefully, he will have served as a co-leader with an experienced leader and have recourse to professional consultation. Being a group leader requires enthusiasm and a drive for continuing education.

1. Single leader or co-leaders
2. Sex of leader(s) - Mixed groups function far more effectively if they are led by opposite-sexed co-leaders.

B. Group Members:

The decision of whether a child should be placed in group counseling or not is often one of expediency - what is available. Many therapists feel group is the best choice of help for the adolescent. Counter-indication however may arise when a child's needs are not likely to be best served because of the composition of the group. Occasionally a very disturbed youngster may need some individual counseling prior to being placed in a group.

1. Age range of group members.
2. Sex -- mixed group or single sex group.
3. Intelligence range of members.
4. Degree of parental dependence and parental control.
5. Manifested behavior problem, i.e. withdrawal, hostile actions, etc.
6. Degree of familiarity pre-existing among members, i.e. all from same class and school, or mixture from several schools. C6-varies with other decisions.
7. Socio-economic status of members.
8. Social maturity.

III. Group Functioning:

Many decisions in this category rest upon those made in I and II.

1. Open-End vs. Closed Group. Should members be chosen and added only in an initial period of perhaps two weeks, or should new members be added at any time. Co-varies with 2.

2. Time-limited counseling vs. individual need - determined goal progress periods of counseling. A group may be set up to function at specified intervals for a limited period with all members agreeing to participate for the entire period. Conversely, a group may be set up to run for an indefinite period until certain goals are reached. There must be a pre-determined manner by which members leave the group, for example, by group vote.

3. Frequency of meetings. Twice weekly has been our preference where possible. Meeting times must not be subject to change except in very rare instances or by prior agreement, i.e. vacation periods.

4. Duration of meetings. This is often a function of setting. It may be a class period (50 min.) or it may be a longer period involving school last period(s) and possibly after school hours. Transportation is often a key factor in this decision. Setting (IV) enters into this decision.

5. Limits set
   for leader -- Degree of confidentiality must be clearly specified.
   for member -- Limits usually include:
      (1) Confidentiality
      (2) Attendance
         (a) Enforced by school
         (b) Enforced by group
      (3) No fighting
      (4) Participation
   Other limits may be necessary, such as swearing, smoking, etc.

IV. Setting:

The success or failure of group counseling is to a large extent a function of setting. Setting is conceived of as both physical environment and psychological environment, i.e. attitude of school administration, faculty, parents, group members, and other students.

A. Place -- Counseling may be done in the school itself or outside the school. Counseling within the school and during the school day presents additional problems with which the school and/or administration may not be prepared to cope. The following requirements are minimal:

1. Consistency -- same place for all meetings.
2. Privacy -- NO interruptions or possibility of eavesdropping.
   . Youngsters particularly dislike rooms with 2-way intercom systems.
3. Freedom from usual required decorum. Youngster may need to move about, to sit on the floor; some smoking may need to be tolerated initially. Groups usually sit in a circle. There must be the possibility of occasional refreshments such as soft drinks.

B. Psychological Setting

Before beginning a program of group counseling, there must be developed certain attitudes or beliefs regarding the process if it is to succeed. Commitment of concerned others is best acquired in small groups where discussion and interaction occur. Once there is a firm basis for the psychological setting, it will, to an extent, be self-perpetuating.

Some concepts to be developed are:

1. The purpose is not punitive.
2. Members are not chosen because they are "the worst problems in the school" but rather because the administration believes they possess the potential for solving their own problems.

3. This is an innovative program and cannot be judged by inappropriate value systems. For example, a leader may be seen as "over-permissive" when, for certain group purposes, he accepts behavior that would not be accepted in the traditional classroom.

4. Group experience is beneficial for anyone -- not just those whom others designate as problems. Group leaders grow and learn, too.

5. It may be more important for a child to participate in group than in an academic experience at a given time. Group, hopefully, will later facilitate the academic experience. If the concerned others (Administration, faculty, parents, students) do not regard group as important and taking precedence over other activities, it may prevent the youngster from accepting "the contract."

6. Expectancies must be stressed. Changes may not occur for quite a while. Some member's behavior may worsen in the early stages. Not every child will necessarily be reached.

7. The nature of the "contract" must be explicit to concerned others. Teachers and parents must understand that group is an intensive interpersonal relationship upon which they cannot intrude. They must respect the right to confidentiality. When the leader(s) is a member of the school staff, he must wear two hats - and the obligations to his group may require him to withhold knowledge from the administration.

8. In order to develop in-group feeling or rapport, it may be necessary for the group to have field trips or other rewarding experiences. This should not be confused by others as rewarding poor behavior.

9. The Group leader(s) should be kept informed by the school of important events or decisions affecting group members. Parents should be encouraged to communicate through the school.

10. Groups held during school hours may result in greater classroom tension immediately following an intense group experience. The teachers must be prepared for these situations and counseled in handling them.

V. Legal Implication:

No child should be included in group counseling until the parents have fully understood what is involved and have signed a form giving their permission.

Whenever transportation is involved, this should also have a signed permission. The obtaining of these permissions is ordinarily the responsibility of the school administration.

THE COUNSELING PROCESS

Someone has said there are as many different therapies as there are therapists. To some extent this has been our experience. Yet we have certain common experiences and we exchange certain ways of behaving that we have found to be helpful in bringing about behavior modification. This section deals very briefly with our conception of the process and a few suggestions of techniques.

I. Development of Rapport, Understanding of Contract and Verbal Techniques.

Usually this required approximately 3 to 4 meetings. In the initial phase the leader(s) must be more active and verbal than in subsequent phases. Support and acceptance by the leader are very important. In later stages this rapport must be maintained by periodic reinforcement. Nevertheless, it is of utmost importance that "leader talk" be kept to a minimum and ideas be drawn from the group members rather than being stated by the leader. During this stage, the terms of the "contract" are stated and acceptance from the members is sought. The presence of a member who had previous group experience is extremely helpful. The leader states very briefly

1. Purpose of group
2. Time, place, duration of meetings
3. His own commitment to the group, especially regarding confidentiality
4. The four basic limits to be imposed on all members.

Secondly, there follows a period of introduction, exchanging background information, etc. Sometimes sensitivity techniques may be used. All interest, concern, questions asked by one member of another, are rewarded by approval (often non-verbal) by the leader.

Limits and purposes are asked for from the group for several meetings until it is clear that they are understood and accepted. Goal definition is the first step of getting the group underway. In many groups this may be facilitated by the introduction of a vocabulary to handle problems. (See attached sheet.)

Often the leader will open this stage by bringing forth personal material, but not unresolved problems. Members are encouraged to give examples of behavior in the various categories. The next step is to get members to relate specific instances where they have gotten into trouble and for the group to identify the problem area. Much encouragement is given to members identifying with the person relating the incident and telling how this problem has been handled. Maximum encouragement is given to direct interchange among members. Once the contract has been understood, in-group feeling has been developed and problems have been identified, we pass to the second stage.

II. Focusing Group Action on Individual Confrontation and Resistance

In the second stage, individual members receive group attention for the better part of a meeting. The group analyzes the individual's behavior and interprets to this individual why his behavior is getting him into trouble. Often this is referred to as "having the hot seat." Resistance to the group is usual. Here the leader must not intervene except to guide the interaction.

Unless the group can arouse an emotional response in the individual, there is unlikely to develop any change. The leader, however, must not allow the group to attack in so destructive a fashion that no change is possible. The object is to provide alternate behavior patterns and put just enough pressure on old behavior as to push the individual to accepting the alternates and agreeing to try them. Hopefully, social reinforcement will establish the new behaviors. The group leader cannot lead the attack except by indirection. Some vocabulary to maintain focus is in the appendix. Also, he must see that a member is "patched up" before the meeting ends, so that functioning is possible and emotionality is toned down.

III. Group Integration and Working Through

In this phase, the group leader takes the least part. If he has managed to control Stage II, Stage III will develop with only his indirect action. In this phase, group members recognize the value of the group's opinion and cooperate with the group in attempting to change his behavior. In other words, he accepts the group mores and internalizes them.

IV. Termination

This last phase should be dealt with in the last two or three meetings. The leader may openly express his own sense of loss in terminating the group. New directions such as Scouts, school activities and other constructive outlets for new modes of behavior should be presented.

APPENDIX

COUNSELING PROCESS - OUTLINE

Stage I

A. Development of rapport between leader(s) and group, and among group members.

1. Social activities
2. Introduction of each other
3. Encouragement of questions, etc. by members
4. Use of sensitivity techniques

B. Presenting the contract.

1. Meeting time, duration, etc.
2. Limits - leader, group
3. Get group to paraphrase contract at opening of several meetings.

C. Development of verbal techniques, group discussion, and interaction.

1. Use of special vocabulary
2. Demonstration of openess and commitment by leader.

Stage II

A. Identification of problems.

B. Focus of attention of group on individuals.

1. Arousal of emotion by confrontation
2. Development of resistance, defense, etc.
3. Control of group's attack
4. Seeking action commitments
5. "Patching up" process

Stage III Integration of group

1. Acceptance of group standards by members
2. Internalization with behavior changes tried. Constructive alternates of problem solutions with group reinforcement.

Stage IV Termination

1. Utilization of community resources to foster changed behavior.
2. Resolution of member's need to continue group identity.

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SUGGESTED VOCABULARY TO IDENTIFY PROBLEM

1. Easily misled
2. "Small" feelings (basic to much acting out, feelings of being dumb, disliked, inadequate)
3. Flunky (Buys friendship)
4. Easily aggravated (looks for trouble)
5. Withholding - no trust, unwillingness to discuss problem.
6. Family problem
7. Bully (Often arises from small feelings)
8. Misleads others
9. Clowing (Attention-getting)
10. Aggravates other, starts trouble
11. Conning - Lying, fooling, trickery.
12. Getting back at the world.

GROUP TERMS

Hot Seat	Being center of group attention. Asked for by member or given to him by group. Each expected to take his turn.
Getting off the hook	When an individual's behavior is being challenged and the group discussion is turned away from him.
Rubbing Someone's Back	Applied to group member who distracts group and averts challenge to another (Being a flunky).
Conning the group	A non-emotional response designed to get self off the hook. An attempt to turn the discussion to another subject.

ACTIVITY GROUP COUNSELING

Activity group counseling is a technique employed by RFDTC with children between the ages of 6 and 13. The technique is effective with this age group because the children, who are experiencing the initial break from their parents, begin to place increasing importance on the opinions of peers. At this developmental stage children also begin to share with others, to accept group decisions, and to rely on peers for support. Because play is a child's symbolic language and means of expressing feelings, fears and conflicts, activity becomes an essential ingredient of the counseling technique.

There are several differences, however, between activity groups, such as the Boy Scouts, Campfire Girls, etc., and activity groups specifically designed for the purpose of therapy. First, in a therapy activity group the members are not randomly brought together but are selected with a specific purpose in mind. This purpose varies with the individual child. Some children are withdrawn, others have difficulty in relating to peers, and many others are acting out in the school, at home, or in the neighborhood. Many of these children are not achieving and still others are having difficulty with authority. Second, the focus of the group is often upon each individual member rather than upon the group as an entity. For example, the concern is not that all children are playing monopoly, but that each child has an individual reaction to success or failure. Third, the involvement of the members in the activity is analyzed by the group leaders and members, for the purpose of enabling each child to verbalize feelings and emotions which heretofore he has either been unaware of or unable to express. Fourth, in a therapy group the leader is professionally trained in knowledge of personality dynamics, interpersonal relationships, and theories of counseling. With this background the group leader can more effectively understand what is transpiring on a psychological level within the group.

In order for the activity therapy group to fulfill the above-mentioned goals, the activities themselves must be carefully chosen by the leaders according to: (1) what will the game do to each individual member as well as to the group as a whole; (2) will the game aid the leader in learning about the group members; and (3) do the group members possess the mental or physical skills required in the activity. Games become a media for self-awareness and positive change. But if games are to fulfill these purposes, they cannot be used merely to keep children occupied; rather there must be a relationship between the activity observations and the problem-focused discussion.

Group members are selected individually, and an effective group size seems to be six to eight children. The group membership is so constructed that there are diverse personality types included, preventing the behaviors from becoming mutually reinforcing. Thus, a group would not be composed of all withdrawn or all phobic or all acting-out children.

Each group session meets for one hour and a half weekly. The sessions are divided, time-wise, into a discussion section period lasting an hour and an activity section lasting thirty minutes. The first five minutes of the discussion phase is a report by each group member on how well he fulfilled his personal commitment made the previous week. A commitment is a verbal agreement by the group member to improve an aspect of his behavior which gets him into trouble, e.g., if his behavioral difficulty was disobedience, the child would commit himself to obeying his parents during the week.

After the reporting on the commitments, one group member either volunteers or is selected by the leaders to "take group" for that week. This position rotates each week so that all members serve in this capacity. When a member "takes group" it means that he and his problems are the focal point of discussion for that session. All other members are to ask him pertinent questions about school, his family, and his peer relationships. These questions prompt the group member to verbalize his difficulties. From the suggestions or comments made by other group members, he gains insight into how to better handle his own particular situation(s).

At the end of the hour discussion period, activities are introduced. Both table games and group games are used. Group members choose between several activities selected in advance (according to the previously mentioned criteria) by group leaders. During the activity phase of group, the leaders must be critical observers regarding such matters as: who pairs off with whom, how each member accepts defeat, who strives to be the leader, who is the isolate, and who cheats to win a game. These actions are then used by the leaders in the following week's discussion period to illustrate an individual's problem. The last five minutes of the activity phase is a verbal summation by the leader of what transpired in group that day, and each member selects his commitment for the following week.

An essential part of the activity group program is follow-up conferences to determine from parents, teachers, and principals, both positive changes in behavior or attitude noted and those aspects still needing improvement. In the conferences, group leaders offer recommendations based on their observations of the child in group. The involvement of school personnel and parents allow a total approach in dealing with the child's difficulties and gives a child a sense of support in knowing significant others are interested in helping him.

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EDUCATIONAL ACTIVITY THERAPY GROUP

The function of treating children who were referred to REDTC due to learning disabilities became increasingly important. It soon became impossible to give individual educational therapy to every child who needed it. Therefore an innovative form of therapy which combined good classroom techniques with clinical techniques was evolved in an attempt to meet the needs of more of the children.

It was found that a number of the children referred to us had moderately severe adjustment problems in school. Physically they were awkward and unable to perform well on the playground. Often they had mixed dominance, directional confusion and a developmental lag in the fine motor skills area. Although often of average or above average intelligence, they were behind academically. These problems discouraged them and "failure sets" became apparent. Some of these children withdrew and did not try to do the assigned work while others became the "class clowns" and manifested disturbing behavior within the classroom.

The educational activity group was designed to help each child admit and, gain insight into his problems, accept himself and work through the difficulties. Therefore, while the materials and methods used were remedial in nature the focus of the group was on helping each individual attain some measure of success through group experience.

REDTC found that this technique, with modification made in consideration of growth and develpment levels, can be used successfully with the elementary school child from ages 6 through 12. Groups were composed of from 4 to 9 children within a one and one half age span who were experienceing similar problems. A part of each 1 1/2 hour session was spent in activities designed to develop gross and fine motor skills. Educational instruction was approached by an eclectic modality method rather than through the usual textbook-workbook methods. Play acivities were selected to implement the skill exercises as well as to develop socialization skills. Thus, each of these facets were intertwined to help the child come to know and accept himself and gain a more positive attitude toward school.

Perhaps the most important phase of the program was the discussion period where each child was encouraged to express himself openly and honestly. These periods were brief and non-structured with the younger children but became a well-defined integral part of each session with the older ones. The ten to twelve year olds were expected to make a commitment toward a specific behavioral change each week and to work toward fulfilling that commitment. While the y ounger children did not express such a goal, they were able to verbalize much insight regarding their feelings and behavior.

Non-directive techniques waiting for the child to respond, taking cues from his behavior and reflecting them verbally, scheduling according to the group's needs and wishes and accepting negative expressions as well as positive ones were important to the success of this endeavor. Conversely, there was a definite time and place for structured activities and adherence to certain rules was expected. At all times, the children were aware of the reasons for participating in each activity. Short range goals were delineated and long range objectives kept before them. The therapists used positive reinforcement, both extrinsic and instrinsic, depending upon the needs of each child.

FAMILY THERAPY AND PARENTAL COUNSELING

Family therapy, although relatively new, offers promise. It gives an understanding between inner and outer experience. It is the therapy of a natural living unit. The sphere of therapeutic intervenion is not a single individual but the whole family. Family therapy sessions include all the persons who share the identity of the family and whose behavior is influenced by a circular interchange of emotion within the group. It is through these sessions that the worker helps the family to assess the relations between the psychosocial functioning of the family group and the emotional status and future of any one member.

Family therapy is uniquely effective with disturbances involving the relations of child or adolescent with family. However, there are instances when family therapy is contraindicated:

(1) Evidence of irreversible trend toward breakup of the family.
(2) Dominance within the family of a concentrated focus of malignant or destructive motivation.
(3) Disintegration of communication having gone too far to allow for intervention.
(4) Unyielding cultural, religious or economic prejudice against intervention in family affairs.

The goals of family therapy are to alliviate emotional distress and disablement and to promote mental health both in the family group and in individual members by:

(1) Resolving conflict and anxiety within interpersonal relationships.
(2) Increasing mutual complementation of emotional needs.
(3) Strengthening the family against critical upsets.
(4) Enhancing the harmony and balance of family functions.
(5) Strengthening the individual member against destructive forces.
(6) Influencing the orientation of family identity and values toward health and growth.

In family therapy it is necessary for the worker to integrate his knowledge and his use of self in a special way. He is a participant-observer, with a heavier emphasis on participation, for he is active, open, fluid, forthright, and at times blunt. His functions might be itemized as follows:

(1) The worker establishes a useful quality of rapport, empathy and communication among the family members and between them and himself.
(2) The worker uses this rapport to clarify conflict and the family's way of coping with it.
(3) The worker uses both confrontation and interpretation to penetrate and undermine resistances and to reduce the intensity of shared conflict, guilt and fear.
(4) The worker feeds into the emotional life of the group more appropriate attitudes, emotions and images of family relationships than the family unit has had previously.

(5) The worker serves as a personal instrument of reality testing.
(6) The worker serves as an educator.

When a REDTC evaluation reveals that a child's learning problem is related to what is happening to him in the home situation, a staff member may arrange to see one or both parents regularly for counseling sessions. This would be done, rather than family therapy, when the problem is not affecting, nor being affected by the total family constellation, or when some of the factors mentioned earlier contraindicate family therapy.

The worker's goals in parental counseling would be much the same as in family therapy. Primarily, he would try to help the parent realize that if the child's behavior is to be modified, the parents must be willing to modify their attitudes and/or behavior.

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MOTHERS' GROUPS

Mothers' Groups at REDTC are composed of mothers who are having difficulties in coping with their children, who have been referred to this agency. In the group the mothers have an opportunity to compare problems, opinions, personal histories, and feelings. The group offers the mothers an experience in relating to others, communicating with them, and in being themselves. The mothers become involved in helping each other in dealing with problems and in pointing out how their own behavior is affecting their children. Experiences are shared and suggestions are made in dealing with daily situations and problems faced with their children.

Mothers' Groups at REDTC are conducted in various ways, depending on the therapist and his approach to group therapy, and also the composition of the group based upon diagnostic impressions, evaluation of problems, and goals of interest. Three of the methods are the following:

1. The didactic method which consists mainly of lectures by the therapist. In this approach the therapist is looked to as the authority figure, who gives solutions to problems.
2. The free-interaction method, in which the interaction between group members during the group session is seen as a reflection of the individuals when they are outside the group. The group members are made aware of how they are perceived by other individuals.
3. A group in which emotions are discounted and only actions are heeded. In this group what a person says is unimportant but what she does is very important.

In the Mothers' Groups at REDTC one of these methods might be used or maybe a combination of these techniques is chosen as the best form of treatment.

Prior to entering a group the mothers are usually asked to make certain commitments. An example of this would be that the mother would be required to be open and honest in expressing her feelings about herself and toward the other group members.

The purpose of the Mothers' Groups at REDTC is to help the mothers modify their behavior in areas where they are having an adverse effect on their children so that in turn the children's behavior will be improved. Hearing others assuming responsibility for changing encourages the mother to face up to her responsibility for change. Facing up to some of her feelings and ventilating them can lessen the anxiety and change her attitude and free the mother to action. Listening to others report having been successful, perhaps through simple modification in behavior, encourages the mothers to realize that change can occur and can motivate them to modify their own behavior. Often when the mother involves herself in modifying her behavior, the behavior of her child is affected and the end result is that the child no longer is in need of REDTC's services.

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It is notable that:

1) 57.9% of children with a severe reading disability were judged as improved.

2) 77.8% of the severely withdrawn children showed mild or marked improvement, whereas only 44.4% of the moderately severe withdrawn children showed mild or marked improvement. This is highly significant ($p<005$).

3) 60.6% of children with severe reading problems were seen as improved behaviorally by the school. 57.9% of those children were seen as educationally improved by the school. Children with severe reading problems tended to improve behaviorally more than educationally. It may be that the alleviation of the associated behavioral difficulty is the first effect seen of the treatment of the child with both severe reading disability and behavior problem.

7. Consensual Judgment of Change - Of the total sample, the following table illustrates the percentage of consensually judged change of each type:

Worse	.3%
Same	22.6%
Mild	60.9%
Marked	16.2%

The relationships of the items in the client form to the consensual judgment are summarized below.

More improvement was seen in girls than boys. This is illustrated in Figure 24 and was significant ($p<01$).

Age was not significant. The trend was for more improvement in the oldest group, generally mild improvemtnt. The next most improvement was seen in the youngest age group.

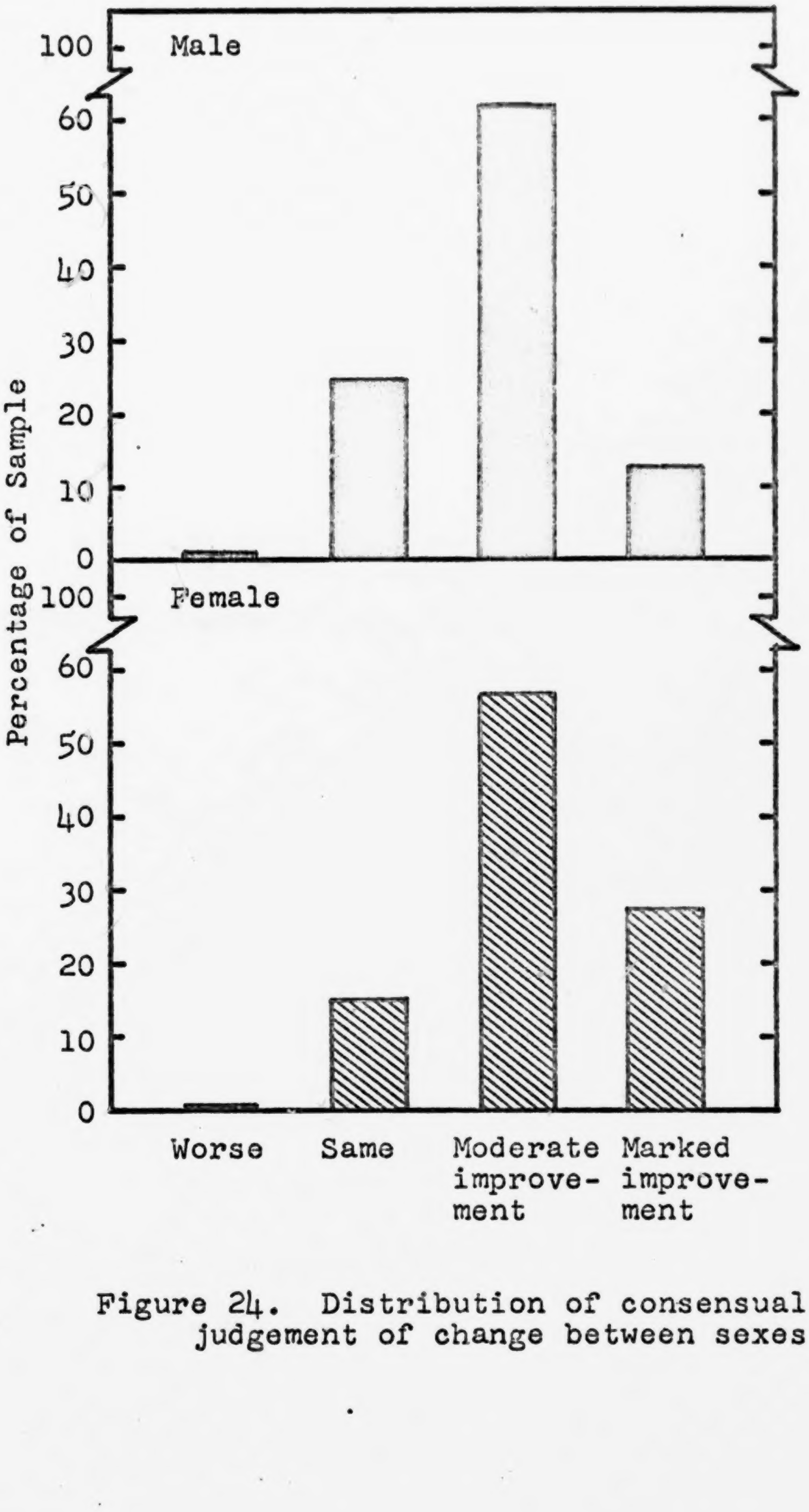

Figure 24. Distribution of consensual judgement of change between sexes.

The following table indicates the percentage of improvement (sum of mild and Marked) by school type. This is significant ($p<005$).

Suburban	86.6%
Inner City	71.1%
Urban	65.6%
Rural	63.9%

The percentage of children showing mild or marked improvement in each school system is as follows: (This is not statistically significant.)

Bullitt County	71.0%	Louisville	68.5%
Catholic	80.6%	Oldham County	92.8%
Jefferson County	82.8%		

The relationship of intellectual potential was not statistically significant. It is noted, however, that 100% of the superior cases improved and 80.9% of the children in the bright normal range improved. Least improvement was seen in the dull normal group (69%).

The findings in regard to aggression and withdrawal were not statistically significant. The trend was toward most improvement in the moderately aggressive or moderately withdrawn child.

In the areas of motor coordination, there was a trend toward more improvement in those who had marked disability than in thosewith mild disability.

The trend in health problems was toward more improvement for those who had had untreated problems but less improvement was seen in those with treated problems.

More improvement was seen in children who had perceptual handicaps than in those who had none. This was not statistically significant.

The following table indicates the relationship of at least mild improvement to socio-economic level. (no statistical significance)

Unemployed or on Relief	81.8%	Managerial	82.6%
Unskilled	70.5%	Professional	100.0%
Skilled	75.1%		

5. School Judgment of School Work - The school judged .9% of the total sample as not applicable. The following table indicates the percentage of children judged as changed in school work by the school:

Worse	6.1%
Same	34.0%
Mild	40.7%
Marked	18.3%

This table shows the perceived improvement in school work for each school system:

Oldham County	77%	Catholic	61%
Bullitt County	64%	Louisville	51%
Jefferson County	63%		

There was a slight non-significant trend to judge girls more improved than boys.

6. School Judgment of Relationships - The "Does Not Apply" category contributes only .6% of this judgment. The percentage of judged change follows:

Worse	2.3%
Same	36.0%
Mild	41.6%
Marked	19.5%

The next table indicates perceived behavioral improvement in each school system (sum of mild and marked):

Oldham County	76%	Jefferson County	60%
Bullitt County	64%	Louisville	59%
Catholic	61%		

These differences were significant ($p < .05$). The schools perceived the greatest percentage of improvement in behavior in the moderately aggressive child, but the least improvement in the severely aggressive child. It is interesting to note further that the moderately withdrawn child was also perceived as most improved, but that a higher percentage of the severely withdrawn children were seen as improved than of the severely aggressive. These trends were, however, not significant.

c) The high degree of parental non-cooperation contributed to the low percentage of parent conferences in the Louisville System.

d) The school conference was utilized maximally for children with educational problems.

e) More parent conferences were held with parents of withdrawn children than parents of aggressive children.

2. Ongoing Consultation - (Any series of more than three conferences regarding a single case was defined as ongoing consultation.) More consultation was utilized for boys than girls. The distribution of consultation by school type is indicated in Figure 23. 80.5% of the children with severe reading problems or non-readers received educational consultation ($p<005$). 57.7% of the children with severe aggression problems had behavioral consultation.

3. Adjunctive Services - These services were provided largely by the REDTC nurse and involved audiometric and telebinocular assessments as well as general health screening. 13% of the total sample received adjunctive services. A total of 586 cases received telebinocular and audiometer tests during the three years. There was a tendency toward more utilization of adjunctive services for children who manifested problems of withdrawal. 11.2% of the total sample were found to have untreated medical problems seriously affecting school adjustment. Often these were discovered by health screening, one of the adjunctive services.

4. School Change - One of the methods of altering the environment was the recommendation by the REDTC of a change in school. Such changes were recommended in 12.1% of the total sample. Of the changes recommended, 59.5% were for children who had severe reading problems. This method was not utilized often in dealing with behavioral difficulties, particularly withdrawal. 50% of these

school changes were within the Louisville System, 28.6% in the Jefferson County System, 19% in the Catholic System, and 2.4% in the Bullitt County System.

5. Referral to Another Agency for Primary Care - Cases were referred to other agencies for reasons of severity of pathology, appropriativeness of resources, projected length of time of therapy, etc. A more complete description of community resources may be found in Section IV. Of the total sample, 27% were referred to another agency. This was generally not possible for children from Oldham and Bullitt Counties. A significant number of severely withdrawn children ($p<.005$), 77.8%, was referred elsewhere; 38.9% of the moderately severely withdrawn children were referred. Of the children referred to other agencies, 19.1% had moderately severe or severe aggression. 56.4% had moderate problems of aggression.

6. Parent Therapy - Parent therapy was done both individually and in groups and might involve one or both parents. A more detailed description of mothers' groups is enclosed in Appendix III (Enclosure 9). Of the total sample, 11% received parent therapy; 6.1% received individual treatment and 4.9% received group. There was a tendency for parents of boys to receive individual treatment and the parents of girls to receive group treatment. The greatest percentage of parent therapy (nearly 50%) was done in Jefferson County.

7. Individual Education - This method of intervention involves more than simple tutoring. A complete description of this prescriptive teaching method is in Appendix III (Enclosure 3). 21.6% of the total sample received individual educational help. There was a tendency to treat boys individually more than girls. 49.6% of the severe reading disability group received individual educational treatment, while 31.3% of the non-readers were treated individually.

The following table represents the percentage of cases in this sample in each school system who received individual educational treatment:

Oldham County	37.5%	Louisville	17.1%
Bullitt County	29.0%	Catholic	16.4%
Jefferson County	24.6%		

8. Individual Behavioral - Individual behavioral treatment utilizing eclectic techniques was carried out by the REDTC staff members, usually on a weekly basis. The duration of treatment varied widely, from approximately six weeks to two years. Of the total sample, 15.6% were involved in a program of individual behavioral treatment. The following table indicates the utilization among the school systems:

Jefferson County	20.7%	Catholic	11.9%
Oldham County	18.8%	Bullitt County	6.5%
Louisville	14.4%		

Individual behavioral treatment was utilized more for withdrawn children than aggressive ones.

9. Group Educational - Group educational treatment was a new technique innovated by the REDTC staff. It involves small groups of no more than five children working together on common educational difficulties. This technique was developed during the REDTC's last year of functioning and consequently only 1.7% of the sample were treated by this method. Of those treated, two-thirds were enrolled in the Louisville System. 83.3% of those treated by this technique had severe reading problems.

10. Group Behavioral - Group behavioral techniques, as described more fully in Appendix III (Enclosures 5 & 6), were introduced in the Kentucky schools by the REDTC. 25.9% of the sample were treated by this method. A higher percentage (28.8%) of all boys than of all girls (16.3%) was treated by this method. Group techniques were utilized primarily for behavior problems of

aggression, although many of the children involved presented a mixed symptomatology. The following table represents the percentage of children for each system involved in group behavioral treatment:

Bullitt County	71.0%	Louisville	18.0%
Oldham County	37.5%	Catholic	11.9%
Jefferson County	27.9%		

11. Group Educational and Behavioral - Group educational and behavioral modification was another technique devised by the REDTC staff. It is a very new technique, which began in the summer of 1968. Therefore, only 1.7% of the sample were involved in this type of treatment. Of these, 50% were in the Louisville school system.

OUTCOMES

1. Staff Judgment of Behavioral Change - The staff judgment of behavioral change was based upon the sample of children which remained in a treatment program directed primarily by a REDTC staff member. Those cases which received no treatment by the REDTC were not judged by the staff. 49.6% of the sample were not rated by the staff in regard to behavioral change. The following data have been corrected (N = 175). The following table indicates percentage of judged change:

Worse	2.9%
Same	18.9%
Mild	48.6%
Marked	29.7%

The next table shows percentage of improvement for each of the school systems:

Bullitt County	90%	Catholic	76%
Oldham County	89%	Louisville	75%
Jefferson County	77%		

Of the few children judged as becoming worse by the REDTC staff, the severity of aggression seemed positively related to failure of improvement. This was not true for severity of withdrawal. There was a non-significant trend for less perceived behavioral improvement in children who also had severe reading disability.

2. Staff Judgment of Educational Change - Of the total sample, 66.3% were not judged by the REDTC staff. No children were judged as becoming worse in this category. The following table indicates the percentage of the corrected sample (N = 117) judged as changed educationally by the REDTC staff in the following ways:

Worse	0.0%
Same	22.2%
Mild	54.7%
Marked	23.1%

The following table indicates percentage of judged improvement (N = 117) for each school system:

Oldham County	100%	Jefferson County	83%
Bullitt County	92%	Louisville	60%
Catholic	87%		

3. Parent Judgment of School Work - Of the parents, 12.8% either did not reply or judged that certain of the questions did not apply to their children. The data have not been corrected for this. The following table indicates the percentage of the total sample judged by the parents to have changed their school work in the following ways:

Worse	4.0%
Same	22.6%
Mild	42.9%
Marked	30.6%

The percentage of parental judged improvement in school work in each of the systems is depicted in the following table:

Oldham County	90%	Louisville	70%
Jefferson County	76%	Catholic	63%
Bullitt County	74%		

There was a trend for parents to judge girls more improved educationally than boys.

4. Parent Judgment of Behavioral Change - Of the parents, 12.8% either did not reply or judged certain of the questions as not applicable to their children. No correction for this has been made in the data. The following table indicates the percentage of children judged by the parents to have changed behaviorally in the following ways:

Worse	2.0%
Same	25.2%
Mild	40.2%
Marked	32.6%

The percentage of parental judged improvement in behavior in each of the school systems is shown in the following table:

Jefferson County	77%	Oldham County	64%
Catholic	75%	Bullitt County	61%
Louisville	65%		

No parents of severely aggressive or moderately severely aggressive children judged their children as becoming worse. Only 22% of the parents of such children judged them as having remained the same. Similarly, no severely withdrawn or moderately withdrawn children were judged as becoming worse. 42% of those children were judged as unchanged. Parents judged a greater percentage of boys as unchanged than girls. The net result of this was that a higher percentage of girls was seen as improved.

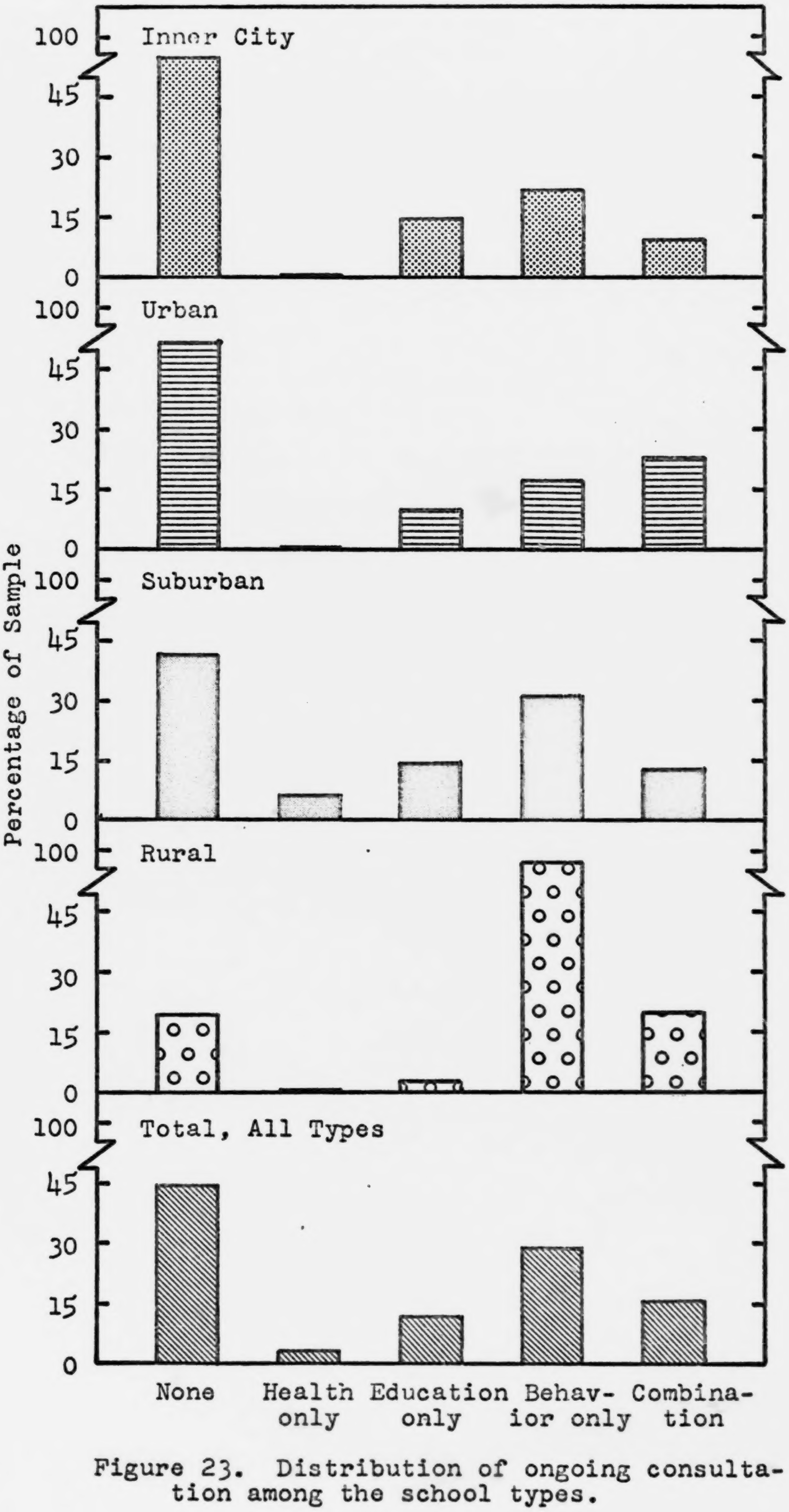

Figure 23. Distribution of ongoing consultation among the school types.

PART II

SPECIFIC LEARNING DISABILITIES

Characteristics and Guidelines for Prescriptive Teaching

Educators, psychologists and doctors use a variety of terms to refer to a child who has a reading disability; among them are dyslexia, strephosymbolia (meaning "twisted symbols"), special learning disability, and word blindness.

Educational Specialists at the Regional Educational Diagnostic-Treatment Center prefer the term *specific learning disability*. This designation was proposed by Samuel Orton in 1937, to refer to children with a disability in learning to read because of a neurological dysfunction. It is assumed that these children have normal potential; the objective is to develop this potential through specialized individualized teaching. However, unless these children are identified through educational and psychological investigation, there is little likelihood that any efforts at individualized teaching will occur.

Before identifying a specific learning disability, the level of capacity for learning must be assessed. If this has not been established, a psychologist from REDTC will administer the necessary tests. He may also give a body image test and a visual motor gestalt test. Results from these tests are discussed in a staff meeting, along with the results of the educational specialist who will test or check the following:

Reading and Writing Skills: A number of good diagnostic tests are commercially available to test reading skills. Performance on these tests indicate whether the child has difficulties in visual discrimination. Myklebust uses the term *visual dyslexia* to describe this disability. Such a child might confuse internal detail (top for tip), or confuse letters which appear similar, such as b and d, or demonstrate inversion tendencies, u for n, m for w. He may make similar errors in spelling. Myklebust states that except for those who are dysgraphic (unable to copy), one of the limitations in spelling is a result of the inability to read. Until a child can interpret and remember words, he cannot use them for spontaneous written expression.

Memory and Discriminatory Impairments: These may be auditory or visual. Since reading requires both auditory and visual memory, an impairment in ability to retain information in either modality can cause difficulty. A child with a visual memory impairment may be unable to revisualize letters and words. On the other hand, a child with auditory memory problems may be unable to remember letter sounds for the purpose of putting them together to make words. This deficit interferes with the development of syllabication skills; because of an inability to break words into syllables, entire syllables may be omitted in written work. He may also demonstrate an inability to sequentialize. The educational specialist will present numbers, letters or words orally and ask the pupil to repeat them.

Left-Right Orientation: These children often cannot identify left and right on themselves, others, or inanimate objects. Consequently, they do not understand directions involving the use of right and left and fail to follow instructions.

PART II (continued)

Deviate Motor Pattern: Although the relation of motor coordination to reading is not clearly understood, the child who manifests obvious difficulty in gross motor coordination such as the ability to skip or hop, will have difficulty with the fine motor skills necessary for success in writing.

Behavior Symptoms: Another indication of the presence of a learning disability can be noted by observing behavior symptoms such as hyperactivity, distractibility and impulsivity. Emotional problems should also be noted. These may be separate entities or a result of lack of success in school, and may take the form of withdrawal, excessive fantasy, hostility or aggressive behavior.

After all tests have been corrected and studied, the case is discussed with members of other disciplines in a staff meeting, and arrangements are made for a school conference. If it is impossible for the teacher to be present at this conference, the educational specialist will schedule a separate conference with her to discuss proposed educational techniques. These techniques may be carried out by the special reading teacher at the school or an educational aide from REDTC, but the classroom teacher should be aware of and implement the procedures in her work with the child in the classroom. For example, a child who has a learning disability concentrated in the visual modality cannot learn from a whole word approach, because it is difficult for him to retain an entire sequence of letters, but he can learn individual sounds and blend them into words. The approach to remediation which has been most successful with this type of disability is referred to as the alphabet or phonovisual. On the other hand, a child with deficits in the auditory modality can learn words as wholes but, in the early stages of training, cannot learn through phonics. With proper educational procedures, both types of children can acquire a sight vocabulary and phonetic skills. It is the initial training which varies.

Deficits in input, listening and reading, are more debilitating than deficits in output, speaking and writing, because the child lacks the tools for the purposes of inner language and conceptual ability. It must be remembered that these children are neither deaf nor mentally deficient. They hear but do not interpret what they hear. Inasmuch as children with severe auditory receptive disabilities have difficulty in listening and fatigue easily, the daily classroom routine should be planned so that auditory and nonauditory activities are alternated. For this reason, the teacher should reduce the amount of language she uses. She will teach concrete words which represent common experiences rather than isolated sounds. For example, cup refers to objects used for containing milk, coffee, tea, and other liquids. During the initial stages, she will teach words that sound different rather than those that are difficult to distinguish, such as pen and pin.

Besides the visual and auditory modalities, the basic means of learning, there are two other avenues, the kinesthetic and tactile, which are effective particularly when both auditory and visual discrimination are poor. Kinesthetic adds a motor activity to the learning process. An example is tracing or outlining a large letter or word -- and doing it over and over again. Motor activity of this kind reinforces what the eye is seeing. Tactile means *touch*; for example, on sandpaper. This method is similar to the ways blind children are taught. In touching, the child becomes aware of the size and shape of a letter.

PART II (Continued)

In working with Richard, who was poor in both auditory and visual discrimination, the educational aide used both the kinesthetic and tactile approach. He was asked to trace large letters with heavy black crayon and then to trace over the letters with his index finger.

It must be remembered that each child has his own set, or combination of problems and circumstances. No two are identical. Learning problems do have definitive patterns, and if the child is accurately diagnosed, he can be taught with specialized educational procedures.

PART III

PRESCRIPTIVE TEACHING FOR CHILDREN WITH LIMITED INTELLECTUAL ABILITY

The REDTC Educational Specialist must often deal with children whose mental capacity is limited. These are the children with IQ's between 65 and 80 on an individual intelligence test.

These children are subject to many of the concomitant behavior patterns of the child with normal ability. Their limited mental capacity sometimes obscures other problems which also act as a deterrent to the learning process. An evaluation by REDTC specialists will determine the best procedures to follow.

The Educational Specialist is able to help the child with limited mental ability in a variety of ways. She can make a careful appraisal of the child's academic potential based upon the results of the intelligence tests and her diagnostic educational tests.

The specialist is then in a position to set up educational goals for the child in keeping with realistic expectations. The specialist will cooperate with the school in determining the best class placement for the child. If the school system does not offer a special class with a teacher trained in this area, the REDTC Educational Specialist will act as a consultant to help the regular teacher so that she will better understand the child and make adjustments in her classroom procedure.

PART IV

PRESCRIPTIVE TEACHING WITH THE EMOTIONALLY HANDICAPPED

The REDTC Educational Specialist functions as a member of a multi-disciplinary team in helping teachers plan a prescriptive teaching program for the emotionally handicapped youngster. With such youngsters, the education procedure is planned along the lines of lessening the demands and setting realistic academic goals. As the child develops an insight into his problems and feels accepted, demands can gradually become greater. It is the normal learning processes that have been impeded; consequently, specific teaching techniques and materials are not a primary concern. When the emotional disturbance is alleviated, these children will learn.

In order to hasten this process, an educational aide works individually with the child. An open channel of communication is maintained between the classroom teacher, the educational aide, and the educational specialist.

PART V

THE EDUCATIONAL AIDE

One part of a prescriptive teaching plan may be to provide the child with individual educational aid. After consulting with the classroom teacher, the educational specialist sets down specific objectives and guidelines to use in tutoring each child. This plan includes the specific methods and materials to be used. The educational specialist then initiates the plan. After a few sessions during which time modifications may be made in the initial plan, the responsibility for implementing it is turned over to the educational aide.

The educational aide is a para-professional who is trained by the educational specialist to work with specific children using a particular prescriptive teaching plan. He, or she, learns through on-the-job training, in-service programs and weekly conferences. She is considered a part of the multi-disciplinary team and, as such, may participate in case staffings and school conferences. At the present time, REDTC has one aide working with each of its three specialists. The educational aide keeps a record of the child's progress and needs, and discusses any changes in the child's behavior or program with the educational specialist at weekly conferences. The child's prescriptive teaching program is re-evaluated periodically as the need arises. The classroom teacher is kept informed as to any proposed changes.

The educational aide is an important part of the REDTC organization in that her weekly contacts with the children provide the staff with feedback as to the effectiveness of the educational plan.

As education moves toward a more individualized approach, in an attempt to help every child reach his potential, teachers will rely more and more on educational aides. With this assistance, they will be able to spend more time with innovative and creative teaching.

TESTS USED BY EDUCATIONAL SPECIALISTS AT REDTC FOR EVALUATION

Auditory Discrimination Test
Joseph M. Wepman, Phd., Chicago, Ill.

Botel Reading Inventory
Follett Publishing Co., Chicago, Ill.

Diagnostic Chart for Individual Difficulties
Fundamental Processes in Arithmetic
Bobbs-Merrill Co. Inc., Indianapolis, Ind.

Examining for Aphasia
Jon Eisenson, The Psychological Corporation, New York, N.Y.

Gates-MacGinitie Reading Tests
Teachers College Press, New York, N.Y.

Gray Oral Reading Tests
Bobbs-Merrill Company, Inc., Indianapolis, Ind.

Illinois Test of Psycholinguistic Abilities
Samuel A. Kirk and James J. McCarthy

Lee-Clark Reading Readiness Test
McGraw-Hill Company, Monterey, Calif.

Metropolitan Achievement Tests
Harcourt, Brace and World, Inc., New York, N. Y.

Peabody Picture Vocabulary Test
American Guidance Service, Ind., Minneapolis, Minn.

Phonovisual Diagnostic Test
Phonovisual Products, Inc., Washington, D. C.

Roswell-Chall Diagnostic Reading Test
Essay Press, New York, N. Y.

Silent Reading Diagnostic Tests, Bond-Clymer-Hoyt.
Lyons and Carnahan, Chicago, Ill.

Stanford Achievement Tests
Harcourt Brace and World, Inc., New York, N.Y.

Stanford Diagnostic Reading Test
Harcourt Brace and World, Inc., New York, N.Y.

The Basic Sight Word Test (Dolche)
Garrard Publishing Company, Champaign, Ill.

The Harris Test of Lateral Dominance
The Psychological Corporation, New York, N. Y.

The Marianne Frostig Developmental Test of Visual Perception
Consulting Psychological Press, Palo Alto, California

The New Developmental Reading Tests -- Bond-Balow-Hoyt
Lyons and Carnahan, Chicago, Ill.

The Orzeck Aphasia Evaluation
Western Psychological Services, Beverly Hills, California

Wide Range Achievement Test
Guidance Associates, Wilmington, Delaware

Academic Disability Scale

Grade	Mild	Moderate	Severe
1	3 mos.	4 mos.	6 mos.
2	6 mos.	9 mos.	1 - 1½ yrs.
3	6 mos.	½ - 1 yr.	1 - 2 yr.
4	6 mos.	1 yr.	2 - 3 yr.
5	6 mos.	1 yr.	2 - 4 yr.
6	1 yr.	2 yr.	3 - 5 yr.
7	6 mos.	1 yr.	2 - 6 yrs.
8	1 yr.	2-3 yr.	3 - 7 yr.
9	6 mos.	1 yr.	2 - 8 yr.
10	6 mos.	1-2 yr.	2 - 9 yr.
11	1 yr.	1½-2 yr.	3-10 yr.
12	1-2 yr.	2-3 yr.	3-11 yr.

The Academic Disability Scale was designed to serve as a guide for Items 13, 15, 17 and 18. The degree of disability was arrived at by determining the retardation in years or months, which would assign the child to a particular category.

The following skills are included under Item 14 (Reading Mechanics Disability):

1. Letter Recognition
2. Phonic Skills
3. Eye performance following a target
4. Use of Configurational Clues
5. Use of Contextual Clues

If the child has a disability in any of these areas which is the underlying cause of poor reading achievement, he can be said to have a "severe" Reading Mechanics Disability. If the disability is mentioned but it is not seen as one of the primary causes of the reading problem, then the child can be said to have a "moderate" Reading Mechanics Disability.

Item 16 - Writing Disability

If the quality of the handwriting is so poor as to make it illegible, it is a "severe" disability. If the handwriting is mentioned as being of poor quality, but it is not seen as a major factor in the child's academic disability, then it should be marked as a "moderate" writing disability.

1	2	3	4	5
Aggressive Behavior				
Normal	disobedience marked carelessness persistent procrastination quarrelsomeness overly boastful	teasing cheating threats (verbal) provoking others lying class-cutting manipulativeness	stealing persistent truancy vandalism repetitive running away	external cruelty wanton destructive behavior homocidal behavior firesetting physical attacks sadistic behavior psychotic exhibiting aggression internal masochistic behavior self-injury behavior suicidal gestures and attempts
Isolating Behavior				
Normal	self-centered inhibited behavior excessive shyness loner; chosen last	suspiciousness rejecting behavior mild phobic behavior extreme immaturity and dependency scapegoat excessively compulsive socially isolated	narcissism excessive fantasy crippling phobia	autistic psychotic exhibiting withdrawal

ADDITIONAL INSTRUCTIONS FOR CLIENT CLASSIFICATION FORM

Item 8 - "Basic" is equivalent with "low track". Avg. should read Adv. for Advanced.

Items 14 - 18 - Additional category of "Does not Apply".

Item 24 - Perceptual handicap does not refer to receptor dysfunction but to intermediary dysfunctions. It includes such findings as auditory and/or visual discrimination, spatial relationship, sequencing and body orientation problems. Do not score for laterality problems alone.

Items 27 - 28 - Medical problems (other than visual or hearing difficulties) which have played a determining role in the child's ability to learn or adjust to school are included here. Example might be poliomyelitis, epilepsy, tuberculosis, severe allergic reactions, chronic upper respiratory infections, malnourishment, etc. Untreated problems are those which have not at any time received medical treatment.

(31) Family Problem (within existing family constellation)

Normal				Severe
1	2	3	4	5

1. Normal - no problem present
2. Problem present but family constellation intact and members able to function
3. Problem creating tension which is adversely affecting communication between one or more family members
4. Problem causing breakdown of one member and affecting total family
5. Severe - complete breakdown of family stability

APPENDIX III

STRUCTURE

REDTC personnel is housed in the K.E.A. Building, 101 W. Walnut Street, and occupies nearly the entire 4th floor. The physical plant consists of a large Conference Room for various meetings, two Play Therapy rooms with a two-way mirror installed, a reception room, and 18 individual offices. Due to the increase in our personnel, we have had to double-up in some of the offices.

REDTC services the schools, public and Catholic, in Jefferson, Bullitt and Oldham Counties, by means of going to the schools for counseling, testing, conferences, or giving remedial instruction. Children may also come to the office for some services, especially during the summer months. Mothers' Groups also meet at REDTC.

In order to concentrate the activities of the staff, three groups have been formed with a specific geographical area assigned to each group for the purpose of servicing the children who are referred to REDTC from the schools within their area. These T-Groups (for "Team") are composed of the various disciplines represented at REDTC. In other words, each T-Group will have a psychologist, a psychometrist, a social worker, an educationist and an educational aide. The nurse is available to any one of the teams, as required.

Detailed descriptions of the various functions of the staff, i.e. Activity Groups, Group Therapy, Play Therapy, Educational Therapy, etc., will be presented in workshops during this conference.

HEALTH SERVICES

The REDTC health service may take many forms. A health survey for a child referred may be requested for any number of reasons: the general appearance, obvious signs and symptoms, performance on a test, a history of some difficulty, or an accident. Those children with a learning disability are given a health screening which includes vision, hearing, and laterality tests.

These tests are used to indicate if a child is having sufficient difficulty to warrant further professional testing by a specialist in a particular field.

Vision is tested with the telebinocular rather than the Snellen Chart, because it provides both far and near point visual information. This is particularly valuable in checking the elementary student, as well as the more advanced students who are required to make heavy demands on their eyes in reading. Another advantage is that for those children who have difficulty distinguishing letters, such as b, d, p, etc. visual acuity can still be tested.

Hearing may be evaluated in terms of ability to hear everyday speech under everyday conditions. The Audiometer test will indicate at what level and frequency the child is having difficulty with hearing. An impairment may be so mild as to require just a better seating arrangement in the classroom, or severe enough to warrant referral to an audiologist who may do corrective surgery or fit a hearing aid.

The laterality test can show if a child is having difficulty with dominance. (We can put these three tests together and find some interesting and unusual patterns that may cause a child real difficulty.) For example, if a child is right-handed and right-eyed but the right eye is, for some reason, causing trouble, this child may block out the ending of words, have difficulty staying on a line, etc. If this same child is having some difficulty with the left ear - not a gross impairment but just enough that he has to turn toward the right to really hear all the sounds - this child will constantly have to shift positions and turn the head to be able to see and hear.

This service also includes obtaining pertinent medical information from physicians, hospitals, and/or other agencies. Contacting and setting up appointment dates with clinics. In some cases, because of family inability or indifference, some children may need to be transported to various clinics for the needed service.

In some of the smaller counties and schools where the facilities are limited, a teacher may have for the first time a child with epilepsy, and request some information on the subject. Printed material is made available to her. For a teacher to be aware of the type of medication and its effect on the child taking it, is most important. The principal and teacher should always be informed of any child that is on any medication.

In some cases the family has to be involved in this service, for instance a case involving active tuberculosis. This family needs to be encouraged and informed of the importance of regular checkups, and needs to be seen in a T.B. clinic. These must be followed. Some families need information and help concerning nutrition or general hygiene. For those children whose family has no private physician, REDTC incorporates the services of other community agencies. These have included the City-County Health Department; Louisville General Hospital's Pediatric and Neurological Clinics; Hearing Conservation Clinic; Children's Hospital; Hearing & Speech Center; and the Kentucky Commission for Handicapped Children.

PART I

PRESCRIPTIVE TEACHING AND REDTC

Prescriptive teaching is the method which utilizes diagnostic procedures to modify the teaching program to fit the child's academic, social and emotional requirements. It is education's answer to the need for individualizing the learning process.

School systems have tried to meet the challenge of satisfying individual needs while discharging group responsibilities in a variety of ways. Homogeneous grouping, ungraded classes, division of curriculum into levels, and special classes are some of the modifications in use. Controversy continues over the relative merits of these measures. There seems to be agreement that all is not well -- that we are somehow not achieving our often-stated goal, *realization of each child's maximum potential.*

The answers we have been seeking have been available to us for some time. As so often happens, each discipline has been hard at work seeking to understand children with a learning problem. The educator, psychologist, social worker, and health specialist have finally joined forces, each complementing the other in an effort to secure greater understanding of the child and the teaching process. The answer is prescriptive teaching which utilizes the diagnostic findings of these specialists to plan the teaching program so that it might better serve the child's needs.

The Regional Educational Diagnostic-Treatment Center utilizes the concept of prescriptive teaching. The multi-disciplinary approach enables full exploration of the problem which each referral represents. The teaching procedures suggested are the results of all concerned. REDTC is then able to implement the educational plans with the help of an educational aide and by working in a consultative capacity with school personnel.

Though prescriptive teaching is used in some regular classrooms, its application at REDTC concerns learning problems. It is impossible to catagorize children with learning problems, since they come from all socio-economic-cultural groups with different intellectual and physical capabilities. However, certain clusters of behavior emerge that permit us to group them into several general categories such as the following:

1. The Culturally Deprived. Many of the children referred to us are products of the inner-city and of multi-problem families. Victims of instability and social deprivation, they frequently look upon the school with suspicion and think of it as an alien authoritarian force. They manifest "inappropriate" behavior because their values and expectations differ from those of the school.

2. The Culturally Disoriented. These children often behave in a similar manner to those described above, except that they are represented in both the higher and lower echelons of society. The school generally views these children as delinquent or socially maladjusted. These children reject the accepted value system of the culture in which they find themselves.

PART I (continued)

3. The Child with a Learning Disability: Much has been written and said about these children who are variously called "perceptually handicapped" or "dyslexic." They are sometimes described as having minimal brain dysfunction, while at other times their learning disability is said to be the result of a specific learning lag. Many of these hyperactive, highly distractible children often cause the teacher much frustration and frequently disrupt the classroom. Often quite intelligent, they do not seem to respond to normal classroom teaching.

4. Children with Medical Problems: Many youngsters referred have physical or organic problems which have been undetected for a long period of time. The inappropriate, often disturbing behavior noted by the classroom teacher is simply an attempt on the child's part to compensate for his problem. Once the problem is detected and corrective measures undertaken, a modification in behavior can be noted.

5. Children with Limited Intellectual Ability: These children pose special problems for the classroom teacher since they cannot respond to the usual classroom program. While placement in a special class is desirable, it is not always possible. A controlled but enriched program of instruction must be planned for them within the regular school program.

6. The Emotionally Disturbed: Each disturbed child presents a variety of problem behaviors. These may range from hostility and aggression to anxiety, withdrawal and phobias. Many classroom teachers lack the training to work successfully with these children. Again, these children usually do not respond to normal classroom or disciplinary measures, but persist in their inappropriate responses.

The complexity of each learning problem underscores the multi-disciplinary approach. The REDTC staff is able to determine the primary behavior pattern. The remedial plan uses this as its focal point while at the same time attending to the concomitant deficits.

The REDTC educational specialist, then, is a member of a multi-discipline team who evaluates each child and consults with school personnel and parents in an attempt to plan a program of benefit to the child. Specifically, the educational specialist plans a prescriptive teaching program for each child who is having learning difficulties, and works with the school in implementing this program.

was based on a diagnosis and evaluation of the child's learning and behavioral problems. By sharing this evaluation with the school, new teaching methods and techniques evolved. The school personnel also gained greater insight into planning individualized programs based on the needs of each child.

Often the school conference provided a setting where a modified school schedule for the child emerged. Sometimes the school day was shortened; certain subjects were substituted for others and provisions for oral examinations were arranged.

Problems may be thought of in three categories: educational, behavioral and/or a combination of both. The most effective approach where both problems exist was designed to ameliorate both problems by several avenues.

In those cases where educational problems were present, the school personnel were called upon to assist children who had specific learning disabilities and a prescriptive teaching program was initiated. In this case the REDTC educationist acted as a consultant. If such personnel were not available, a REDTC educationist aide worked individually with the child.

As time progressed it became increasingly apparent that individual instruction could not be provided to meet the educational needs of every child. Therefore, educational group therapy was introduced to provide help for more children and to acquaint school counselors with this technique. For the younger child having both types of problems, an innovative approach to learning which incorporated play therapy with classroom methods was devised. Counselors were also utilized as co-therapists in this technique. (See Appendix III, Enclosure 7.) For the older child there was often individual or group counseling and individual educational assistance. (See Appendix III, Enclosure 5.) Again a counselor and/or a teacher were utilized as co-therapists.

The REDTC staff also consulted with school personnel regarding behavioral modification techniques which could be practiced with the classroom. Such suggestions included the utilization of short-term goals and the provision for immediate positive reinforcement. Support and understanding were also given to the teacher as she implemented these procedures. In those instances where behavior problems needed more intensive treatment, the children were either seen by REDTC staff members for individual or group behavioral modification (See Appendix III, Enclosures 4, 5, 6.) or they were referred to another agency for treatment. Also, behavioral modification was carried out by a REDTC staff member indirectly through parent therapy. (Appendix III, Enclosures 8, 9.)

While it is felt that the REDTC made a definite impact upon the schools and contributed significantly to their programs, greater gains could have been made if:

1) There had been a workshop at the beginning of the Center's organization to acquaint counselors and teachers with the function of the REDTC. This would have enabled school staffs to know when and how to refer a child.
2) The evaluation of the child had included observing the child in the classroom.
3) There had been more contact with the classroom teacher. It was often difficult for her to leave the classroom to attend conferences, and it was not always feasible to consult with her during school hours.
4) The physical facilities of the school had permitted better testing and therapy areas. Often interruptions and outside noises were deterrents to the effectiveness of the sessions where confidentiality and a relaxed atmosphere were of importance.

5) Money had been available to transport more children to the Center for play therapy and group activities.

6) All of the schools employed counselors. It was the feeling of the staff that counselors in the schools provided the necessary liaison function in utilizing the Center's services.

7) More counselors could have been freed to serve as co-therapists in groups. Counselors from one school could have been utilized most effectively as therapists in another school. This would also have created an interchange of ideas between the reciprocating counselors regarding the children in those groups.

THE REDTC AND THE COMMUNITY

In many cases REDTC's effectiveness in diagnosing and treating children was enhanced by utilizing community resources. The utilization of a community resource frequently began with the initiation process at the REDTC. Following identifying information on the child and a statement of his problems, it was necessary to determine whether the child had been involved with other social or psychological services. If the child had been involved, information from the agency was requested, with parental permission, prior to any further decision making. Whenever possible, representatives from other agencies with knowledge of the case were included in the REDTC staffings.

In addition to utilizing community resources in diagnosing problems of children, the REDTC referred children to other agencies for treatment services. A referral would be made by the REDTC if:

1) Long term and/or intensive treatment were required.

2) The problem were of a medical nature.

3) Long term family counseling were required.

The REDTC forwarded case summaries to the referral agency and maintained open communication with that agency thereafter. In some cases the REDTC treated the child while the parents were seen in therapy at another agency.

A financial contractual agreement between the REDTC and the Child Guidance Clinic was part of the program from the beginning. This written agreement stated that the Director of the Child Guidance Clinic, a Child Psychiatrist, would offer consultative services to the REDTC staff on a weekly basis. Under terms of this contract, the usual Child Guidance Clinic treatment fees were paid from the REDTC budget for all children referred to that agency by the REDTC.

Verbal agreements which did not involve financial contracts were arranged between the REDTC and several other community agencies. For example, the REDTC provided psychological testing for children already involved in treatment at a family service agency. The REDTC also did psychological screening for the emotionally disturbed class located at a state psychiatric hospital.

The REDTC nurse frequently referred children to community medical agencies for diagnosis and treatment of suspected medical problems; the nurse also used these resources to obtain specialized medical assistance for indigent children.

In September of 1965, an Inter-Agency Council was formed to provide a forum for existing community agencies to exchange knowledge and experience concerning children whose disturbance was puzzling and whose needs could not be met by the service of a single agency. Twelve agencies representing specialized services made up the Council which the REDTC joined in December 1966. The REDTC furnished the secretarial help for the agency. The REDTC's involvement with the Inter-Agency Council facilitated more efficient utilization of community resources and made other agencies aware of the REDTC's services.

Because the REDTC was closely involved with both school personnel and community resources, a reciprocal understanding evolved:

1) The community agencies developed an awareness of the realistic limitations imposed upon schools and school personnel by lack of funds, overcrowding, and lack of personnel.
2) The schools gained an awareness of resources available in the community.
3) The schools assumed greater responsibility in making appropriate referrals on their own. Communication between school personnel and community agencies became more frequent, more open, with mutual trust beginning to develop.

THE REDTC AND THE HOME

An integral part of the REDTC diagnostic service was information regarding the child's home situation and intra-family relationships. This information was obtained by the REDTC social workers through interviews with the parent(s) of the child. Home visits were used to obtain information in cases where the family was unfamiliar with and fearful of agency contacts, or where inaccessibility of transportation or physical handicaps prevented appointments at the Center. In most cases data regarding the home environment influenced, if not determined, the type of treatment services recommended.

As the agency's operating procedures evolved and as the number of children referred increased, REDTC called upon the visiting teachers in some school systems to obtain the family information and/or make home visits. By so doing the visiting teachers brought the school and the home into a closer working relationship.

After completion of the diagnostic phase, an interview was held with the parents, at the REDTC or at the school, to provide test interpretation and explain treatment recommendations. Parental permission was required before any child was placed in a REDTC behavioral program. In some instances, however, parents refused services and the REDTC was not able to implement the treatment plan.

Sometimes the assessment of the child's problem, combined with his home environment, indicated a need for institutional placement. In these instances, the REDTC, the parents, the school, and the receiving institution worked closely together in making the transition for the child as smooth as possible. The REDTC also participated in his return to the school.

Initially some children were referred to the REDTC without prior parental consent. This situation was subsequently rectified, but full cooperation of parents was not always achieved for the following reasons:

1) The REDTC had no authority to insist upon cooperation from the home.
2) The agency was not able to make a home visit in every case where parents did not come to the school or Center.

However, in many cases the REDTC was effective in opening communication between the school personnel and parent. The school personnel became more cognizant of home factors affecting a child's ability to achieve and/or to adjust in school. Families, on the other hand, developed a more positive attitude toward the school and became less hesitant to initiate subsequent parent-school conferences.

THE REDTC STAFF GROWTH AND INTERACTION

During the first two months of the REDTC's operation, the staff consisted of the director, two secretaries and five other professionals representing psychology and social work. In the final year of operation, the REDTC staff had increased to twenty-eight. As the staff increased, other disciplines were represented; educationists and a Registered Nurse, as well as educational aides, were added in 1967. The addition of these disciplines enabled a more extensive evaluation of each child; a wider range of treatment services evolved, and the REDTC was able to provide more consultative services to the schools.

The educational aide, a paraprofessional, was an important part of the REDTC organization. The functions of the aides broadened as a result of the competence they developed and as a response to a steadily increasing number of children who required treatment. The aides worked effectively in the school setting, under the direction of the REDTC educationist, using a prescriptive teaching plan and assisting the teacher with children requiring individual tutoring and attention.

For the first year of operation, cases were assigned to individual staff members for evaluation and diagnosis. It became apparent, however, that a more extensive evaluation could be done on each child and that a greater number of cases could be screened if a team, rather than an individual worker, were involved. Therefore, the staff was divided into multi-disciplinary teams consisting of a psychologist, psychometrist, educationist, social worker, and educational aide. The REDTC nurse provided services for all teams. (See Appendix III, Enclosure 1.)

In addition to the previously mentioned psychiatric consultant, a Ph.D. psychologist was engaged to provide weekly consultative services and to supervise the Masters Degree REDTC psychologists. The psychiatric and psychological consultants provided the REDTC staff with in-service training and with opportunities to discuss cases on an individual basis. At the beginning of the Center's second year some of the staff who were doing individual and/or group therapy felt the need for more staff interaction on the problems encountered in the therapy processes. The psychological consultant agreed to function as the leader for a weekly encounter group whose members were limited to those involved in behavioral modification. After approximately two months, the group was terminated. It is felt that the group did not meet the need for which it was established because:

1) Members did not agree upon the group goals.

2) All staff members were not included.

An encounter group program might have been meaningful if initiated with all staff members earlier in the REDTC's existence. Inter-disciplinary communication and cooperation might have been enhanced had the staff been able to plan for periodic two-day sessions for group interaction. This would have enabled the staff to have developed closer interpersonal working relationships at an earlier date.

The project would possibly have been more efficient and evolved more rapidly had there been a clinical director familiar with the discipline of psychology and social work to assist the Director whose background was necessarily educational.

An additional source of in-service training for the REDTC staff was visiting other agencies functioning in the community.

Throughout its three year existence the REDTC worked with the personnel of the Kentucky Innovative Development Center, a Title III project designed to assist regional programs by disseminating information, providing consultative services and conducting status and descriptive research studies. The Kentucky Innovative Development Center also sponsored seminars and conferences, on both a regional and statewide level, for the purposes of:

1) Acquainting community educational leaders with the functions of Title III Projects and with innovative programming applicable to education as a whole.
2) Providing a forum for staffs of Title III Projects to discuss and/or demonstrate program innovations. The REDTC was represented at several of the conferences sponsored by the Kentucky Innovative Development Center and was the host project for one statewide meeting.

SECTION V

CONCLUSION

This evaluation is a report of the activities and observations of the Center during its three years. It is not a measure, in the experimental sense, of the value of the services rendered. Such a measure was not possible because:

(a) Initially we did not have sufficient data about contributory variables to delineate meaningful control groups.

(b) We were primarily service-oriented and were faced with an enormous service load to which our energies were chiefly directed rather than to research. Our Center serviced a total enrollment of over 190,000 children.

(c) The Center was constantly changing and it is not possible to adequately evaluate an evolving process.

This report, however, indicates several fruitful areas for research. It is unfortunate that the Center was terminated at a point when it would have been possible to have utilized an experimental design to test some of its activities.

One attempt was made to evaluate our effectiveness by a questionnaire sent to schools that had received service. This covered only the period from September 20, 1966 to March 1967, approximately our first six months. These results are tabulated as follows:

148	Satisfactory
17	Moderately Satisfactory
5	Unsatisfactory
39	Undetermined
64	No Comment
273	(Total

No other questionnaire has been utilized. A large number of school personnel have volunteered regret at our being discontinued and their belief that we have been of help to them. We had failures as well as successes. We learned much of the realities of the school environment. We learned to translate concepts and ideas among many disciplines and opened new vistas for ourselves as well as, hopefully, school personnel.

Perhaps the most important contribution the Center made was to emphasize its basic philosophy that we diagnosed problems, not children. We were not interested in affixing responsibility for problems or categorizing them for the sake of labels. We were interested in the here and now, and what was within our power to change. We believed behavior was learned, and that we could provide opportunities for new and better learning. We found that altering environment was often as effective, if not more so, than direct therapy with the child. Our philosophy was to identify the areas in which there was a failure to achieve or to adapt, and devise means of altering the situation. We believed that this could be done only if we were wise enough, flexible enough, and worked hard enough.

APPENDIX I

CLIENT CLASSIFICATION FORM

Name ________________________________

(1-4) __________ ID Number

(5)	Sex:	1 Male	2 Female					
(6)	Age:	1 Below 6	2 6-8	3 9-11	4 12-15	5 16 and Older		
(7)	Grade:	1 Kindergarten	2 Primary	3 Intermediate	4 Jr. Hi	5 Sr. Hi		
(8)	Program:	1 EMH	2 PH	3 Transitional	4 Emot. Disturbed	5 Basic	6 Reg	7 Avg
(9)	School:	1 Public	2 Other					
(10)	School Type:	1 Inner City	2 Urban	3 Suburban	4 Rural			
(11)	School Change:	1 None	2 Normal Promotion	3 Family Move	4 Recd.by REDTC	5 Person Request	6 School Request	
(12)	Intellectual Potential:	1 Retrd.	2 Dull Norm.	3 Average	4 Bright Average	5 Superior		

ACADEMIC PROBLEMS:

(13)	Total Reading Disability:	1 None	2 Mild	3 Moderate	4 Severe	5 Non-Reader
(14)	Reading Mechanics Disability:	1 None	2 Mild	3 Marked		
(15)	Reading Comprehension Disability:	1 None	2 Mild	3 Marked		

(16)	Writing Mechanics Disability:	1 None	2 Mild	3 Marked		
(17)	Spelling Disability:	1 None	2 Mild	3 Marked		
(18)	Arithmetic Disability:	1 None	2 Mild	3 Marked		

BEHAVIORAL PROBLEMS:

(19)	Degree of Aggression:	1 Normal	2	3	4	5 Severe
(20)	Degree of Withdrawal:	1 Normal	2	3	4	5 Severe
(21)	Problem of Sexual Adjustment:	1 None	2 Marked Problems of Identity	3 Excessive Masturbation	4 Promiscuity	5 Other (Fetishism, Exhibitionism, etc)
(22)	Gross Motor Coordination:	1 None	2 Moderate	3 Marked		
(23)	Fine Motor Coordination:	1 None	2 Moderate	3 Marked		
(24)	Perceptual Disability:	1 None	2 Moderate	3 Marked		
(25)	Visual Impairment:	1 None	2 Moderate	3 Marked		
(26)	Hearing Deficit:	1 None	2 Moderate	3 Marked		
(27)	Arrested Medical Problem:	1 None	2 Moderate	3 Marked		
(28)	Untreated Medical Problem:	1 None	2 Moderate	3 Marked		

HOME:

(29)	Socio-Economic Level:	1 Unemployed, on Relief	2 Unskilled	3 Skilled	4 Managerial	5 Professional
(30)	Parent Status:	1 Adopted	2 1 Natural	3 1 Natural and 1 Step	4 2 Natural	5 Other
(31)	Family Problem:	1 Normal	2	3	4	5 Severe

TREATMENT:

(32)	Conference (1 to 3)	1 None	2 School	3 Parent	4 Both	
(33)	Ongoing Consultation:	1 None	2 Health Only	3 Education Only	4 Behavior Only	5 Combination
(34)	Adjunctive Services:	1 No	2 Yes			
(35)	Referral to Other Agency for Primary Care:	1 No	2 Yes			
(36)	Parent Therapy:	1 None	2 Individual	3 Group		

CHILD THERAPY:

(37)	Individual Educational:	1 No	2 Yes
(38)	Individual Behavioral:	1 No	2 Yes
(39)	Group Educational:	1 No	2 Yes
(40)	Group Behavioral:	1 No	2 Yes
(41)	Group Educ. and Behav.	1 No	2 Yes

OUTCOMES:

(42)	Staff Judgment of Behavioral Change:	1 Worse	2 Same	3 Mild Improvement	4 Marked Improvement	5 Does Not Apply
(43)	Staff Judgment of Educational Change:	1 Worse	2 Same	3 Mild Improvement	4 Marked Improvement	5 Does Not Apply
(44)	Parent Judgment-School Work:	1 Worse	2 Same	3 Mild Improvement	4 Marked Improvement	5 Does Not Apply

(45)	Parent Judgment - Relationships:	1 Worse	2 Same	3 Mild Improvement	4 Marked Improvement	5 Does Not Apply
(46)	School Judgment - School Work:	1 Worse	2 Same	3 Mild Improvement	4 Marked Improvement	5 Does Not Apply
(47)	School Judgment - Behavioral Change:	1 Worse	2 Same	3 Mild Improvement	4 Marked Improvement	5 Does Not Apply
(48)	Consensual Judgment of Change:	1 Worse	2 Same	3 Mild Improvement	4 Marked Improvement	

REDTC
April 1969

PARENT CHECKLIST

Please check the one square which fits your child now, as compared to how he was before he was referred to us.

	Worse	Same	Some Improvement	Much Improvement
School Work	☐	☐	☐	☐
Getting along with other children	☐	☐	☐	☐
Getting along with parents and/or other adults	☐	☐	☐	☐

REDTC __________
April 1969

SCHOOL CHECK LIST

Please check the appropriate square for the child now, as compared to how he was at the time of referral to REDTC.

Name: ____________________________________

	Worse	Same	Mild Improvement	Marked Improvement
Attendance:	☐	☐	☐	☐
Frequency Sent to Office for Discipline:	☐	☐	☐	☐
Quality of School Work:	☐	☐	☐	☐
Peer Relationships:	☐	☐	☐	☐
Toleration of Criticism by Faculty:	☐	☐	☐	☐
Self-direction:	☐	☐	☐	☐

REDTC
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Directions for transferring information from forms received from parent and school

I. SCHOOL FORM

1. For Items 1 and 2 (Attendance and Frequency sent to office for Discipline), a score of worse equals 1
   same equals 2
   mild Imp. " 3
   marked Imp." 4

2. For Items 4, 5, and 6 (Peer Relationships, Toleration of Criticism by Faculty and Self-Direction), a score of:

   Worse equals 2
   Same equals 4
   Mild Improvement equals 6
   Marked Improvement equals 8

3. Add up total of scores for 1, 2, 4, 5, and 6. Divide total by 8. This is the score to enter on Item 47 of Client Classification Form (School Judgment of Behavioral Change). If the number you get is a fraction,round it off to the highest number.

4. For Item 3(Quality of School Work), just transfer it over to Item 46 of the Client Classification Form (School Judgment - School Work).

II. Parent Form

1. School work equals Parent judgment of school work.
2. Average of "getting along with parents and/or other adults" scores equals parent judgment-relationships. If you get a decimal, round off.

III. CONSENSUAL JUDGMENT OF CHANGE

Arithmetic average of Items 42, 43, 44, 45, 46, and 47 on the Client Classification Form. Do not include items marked 5.(Does not apply.)

Example:	I.	42	3	II.	42	3
		43	3		43	5 (Omit)
		44	3		44	2
		45	4		45	2
		46	2		46	2
		47	3		47	3
			18			12

(6 divided by 18 equals 3)
Item 48 = 3

(5 divided by 12 =2.4 = 2.0
Item 48 = 2

IF YOU HAVE ANY QUESTIONS, SEE JANE TOWERY, MURIEL K. OR DOROTHY OSSE.

APPENDIX II

This may reflect the acceptance of help by those who either are sophisticated in the area of mental health or who are accustomed to working with agencies.

There was a statistically significant ($p < 025$) relationship between improvement and parent status; the most being with those children having one natural and one step-parent. This may reflect the factor that these were also largely suburban (54.5% of these were in suburban schools).

The improvement seen in those children referred to other agencies was quite similar to that of others in the sample and was not significant.

The data for types of conference and consultation were not significant. A trend indicated that those children for whom only a parent conference was held showed least improvement. Educational consultation yielded more mild improvement than marked whereas the converse was true for behavioral consultation.

The data in this section cannot be viewed as reflecting relative efficiencies of types of treatment because:

1) Some children who comprise the population of "untreated" for any given type were treated by another method.
2) The assignment of treatment method was by no means random. Severity of pathology varied. Exigencies of the situation often determined choice of treatment.
3) Some children received more than one type of treatment.
4) The previously discussed artifacts of the data.

Nevertheless the following table is included for its interest. It should be noted that there was a high frequency of children also receiving treatment when parents were treated and the improvement is statistically significant in this area only. In these cases also, the percent of marked improvement was proportionately higher than in the other treatment.

CONSENSUAL JUDGMENT REGARDING TREATMENT TYPES

Treatment	% Receiving	% Improved with Treatment	% Improved without Treatment	Significance
Referral to other agency	27.2	79.8	76.7	N.S.
Individual play therapy	6.1	90.4	75.3	.025
Group play therapy	4.9	94.1	75.3	.025
Individual educational	21.4	81.1	66.0	N.S.
Individual behavioral	15.7	87.1	75.2	N.S.
Group educational	1.7	88.3	77.0	N.S.
Group behavioral	25.5	71.5	79.0	N.S.
Group educational and behavioral	1.7	66.7	77.3	N.S.

SECTION IV

NARRATIVE EVALUATION OF THE REGIONAL EDUCATIONAL DIAGNOSTIC-TREATMENT CENTER

As stated in Section I, a child's environment is made up of the school, home and the community. In this section, the involvement of the Center with this environment will be discussed with particular attention to the pros and cons of the REDTC's interaction. Staff interaction within the agency will also be discussed.

THE REDTC AND THE SCHOOL

One measure of the extent of influence exerted by the REDTC may be seen in the following table which summarizes the service to this region.

	Anchorage	Bullitt County	Catholic	Jefferson County	Louisville	Oldham County
Number of cases referred	2	138	446	797	827	92
% of Referred Seen	100%	74%	80%	84%	69%	88%
Total Enrollment	317	6,290	39,684	86,537	54,525	3,062
% of Total Enrollment Seen by the REDTC Staff	.6%	2.3%	.73%	.76%	1.0%	2.6%
Total Number of Schools in System	1	9	32	76	67	5
% of Schools Visited by the REDTC Staff	100%	100%	86%	71%	93%	83.3%

The school was the primary source of referral for the Diagnostic-Treatment Center and furnished the setting for most of the agency contacts. The REDTC provided the school with objective specialists who could offer a multi-disciplinary approach.

The REDTC staff served as a catalyst between the parents and the school in planning and implementing an appropriate program for each child. This program